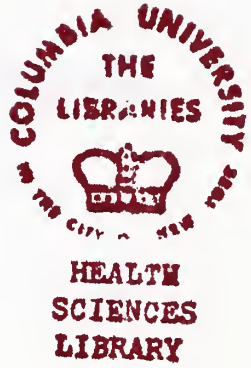
COLUMBIA LIBRARIES OFFSITE
HEALTH SCIENCES RESTRICTED
HR00966266


COLUMBIA UNIVERSITY
THE
LIBRARIES
HEALTH
SCIENCES
LIBRARY

Digitized by the Internet Archive
in 2017 with funding from
National Endowment for the Humanities (NEH)

https://archive.org/details/masareview00medi_0

Volume 2 Number 1, Spring 1998

MASA REVIEW

Incorporating **Alabama Medicine**,
The Journal of the Medical Association of the State of Alabama

SEP 29 1998

MEDICARE
Where do we go from here?

Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800.282.6242/205.877.44(

MASA REVIEW

Incorporating **Alabama Medicine**, *The Journal of the Medical Association of the State of Alabama*

Vol. 2 No. 1 Spring 1998

USPS 284720 ISSN 0738-4947

Editor William A. Curry, M.D.

Managing Editor Amanda Jones

Book Review Editor David W. Hodo, M.D.

OFFICE OF PUBLICATION: PO Box 1900, Montgomery, Alabama 36102-1900. Subscription Prices: member, $15; non-member $30 per year. Periodicals postage paid at Montgomery, Alabama and at additional offices. Published quarterly by the Medical Association of the State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36104.

POSTMASTER: Send address changes to MASA REVIEW, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for the Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1998 by the Medical Association of the State of Alabama.

IN THIS ISSUE

4
Yes, There is a Code of Medical Ethics
By Wayne H. Finley, Ph.D., M.D.

8
Medicare Reform
By Robert Moffit

16
Physician Assistants and Alabama Physicians
George White, PA-C, MASPH, Ph.D., et. al.

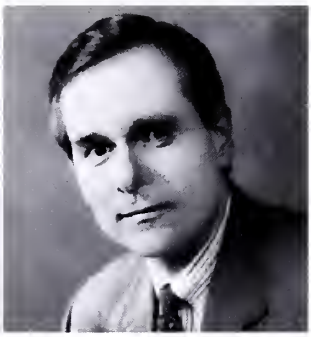
22
Science or Snake Oil: Evaluating WWW Sites
By Judy Burnham, MIS, AHIP

DEPARTMENTS

President's Message 2
Executive Director 3
Book Review 15
Advertisers Index 20
MASA Services 21
Author's Instructions 25
Calendar of Events 26

Professors All

In this issue of MASA Review, Wayne Finley, M.D., traces the roots of medical ethics to the ancient Greek founders of our profession. In the Greek worldview, and in the Judeo-Christian one that followed it, the purpose of public institutions was virtue, both private and public. The current disputes surrounding our own nation's president remind us that this is not the worldview of 1998. The change, though, did not occur at the time of Watergate, or the turbulent 1960's, or the World Wars. It came with the seventeenth century public philosopher, John Locke, who advocated government based on individual freedom. His timing was perfect, as his ideas were swept along in the tide of the Enlightenment, one of whose offspring was our own nation, with its Constitution and founding principles.



We value the freedoms we enjoy as physicians. At the same time, we struggle to keep those freedoms in tension with virtue - with the standards of society, the standards of medical practice, the standards of the professional associations of organized medicine. But if, as Dr. Finley proposes, there really is a "basis for medical ethics," then we must be able to invoke some sort of transcendent principles. Ironically, it is the public philosophy of John Locke, the proponent of personal freedom, that points us toward a solution. It was out of Locke's principles that the concept of Natural Law developed, and so we have the idea that some truths are "self-evident."

From those truths comes the idea of a social contract among the people and with their government, a calling to mutual respect and responsible action. That idea of "calling" is intrinsic to the term "vocation" (from the Latin vocare, to call, and thus vocatio, a call). Today we consider vocation synonymous with career, with how we earn a living. In its original meaning, though, we all have many callings: spiritual callings, callings to personal growth, to family roles and duties, and of course, to our careers.

In the case of medicine, we claim the term profession, the distinction being one of prestige and of self-governance. The derivation of that ancient word brings much meaning, too, from the Latin professus, meaning to take a vow, something physicians over the centuries have done literally, as Dr. Finley relates. It has come to include the religious sense of professing beliefs as well.

So what are you and I professing

Continued on page 28

—William A. Curry, M.D., F.A.C.P.

The First Column

In the last MASA Review, Lon Conner was kind enough to introduce me to you. You may have seen my introduction in the *Alabama MD* upon my arrival, but if you didn't - allow me again to give you some specifics about myself.

I began my employment with MASA on June 20, 1997 and assumed the position of executive director on August 1, 1997. At that time, Lon Conner, the executive director for 21 years, moved to an emeritus status. Mr. Conner retired on December 31, 1997.

I have a B.A. in marketing from Louisiana State University (at least I'm in the SEC) and a MBA from the University of New Orleans and I bring with me 26 years of medical association management. I joined the Orleans Parish Medical Society in New Orleans in 1972 and was named executive director in December 1980. Along with managing that 1,800 member organization, I also served as chapter manager for five specialty societies.

I am honored to have been chosen to succeed Lon and what I learned early on was that MASA is an organization that didn't need "fixing." I was able to come in, have a smooth transition with Lon, take the baton from him and run with it. Also, I was impressed immediately with the composition, commitment and responsibilities of the MASA Board of Censors. The Board is balanced from all aspects—age, gender and specialty—and the commitment to wearing its "three hats" is impressive. Alabama is unique in the country in having the Board, which is elected by MASA members, serve not only as the MASA Board, but also the Board of Medical Examiners and the State Committee of the Department of Health. Alabama is fortunate to have this situation where these three operations have a common goal—high quality medical care for the citizens of Alabama.

Since assuming the executive director position, the Board has approved several significant organizational changes. First, we have taken a strong marketing approach to membership retention and recruitment. Vic McLean handles the marketing side of the operation and has put together a plan to make our membership base stronger by emphasizing the recruitment of young physicians, the future of your Association. He works closely with Emmett Wyatt to make sure memberships are processed accurately and efficiently.

Continued on page 29

—Cary Kuhlmann, Executive Director

Yes, There is a Code

The physician-patient relationship is a time-honored tradition of respect and consideration which is inviolate by members of the profession. How has this evolved through the centuries?

One of the bases of medical ethics is the almost 25 centuries old "Oath of Hippocrates" a form of which has been administered to a majority of graduating American medical students for many years. This oath which begins, "I swear by Apollo the physician, and Asclepius and Hygieia and Panaceia and ....."[1] was found in 300 B.C. at a medical school in Alexandria. The oath and covenant which have been attributed to Hippocrates address relationships between physicians, the practicing of the art of medicine, commitment to treating the sick respectfully regardless of status, pledge to do no harm, desire to be honorable to all, and the challenge to have no peace if the oath is violated.

By Wayne H. Finley, Ph.D., M.D.
Professor Emeritus
University of Alabama
at Birmingham

Hippocrates has been thought to be a descendant of Asclepius whose human existence has been questioned.[2] Asclepius began to be worshipped several centuries before Christ among the poor and lowly classes of Greece. This worship was promoted by Alexander the Great, and was extended throughout the Roman Empire. Asclepius was pictured as mild and kind

Edit
an exp
you will be disap
became a distin
world, you will
may not be the
basis for

and as the ideal physician.[3]

The earliest known practitioners of medicine, Asclepiads (sons of Asclepius) or priest-physicians, worked in temples of healing which were often constructed near mineral springs.[4] Statues of Asclepius, described in antiquity, were constructed in temples and symbolized care for the ordinary and lowly people. Hippocrates, born on the Greek Island of Cos, did his work there. He traveled widely during his long life, he lived about 100 years. Today, on the Island of Cos, the oldest tree in Europe is a Plane Tree (Plananus orientates L. or Oriental Sycamore), whose trunk is cavernous with branches requiring support. Under this tree Hippocrates supposedly taught.[5] His teachings were the first to address ethics in the practice of medicine.

Down through the ages, social developments and the evolution of cultures have produced influences which have further defined and modified the traditions of ethical medical practice. The contributions of the Judeo-Christian teachings and their interpretations have

# of Medical Ethics

f you read this article anticipating
stematic principles of medical ethics,
nstead, you read it to understand how medicine
with universal standards rooted in the ancient
. As with our own families and communities, it
vould choose, but it is the one we have. It is the
esent frustrations and future dilemmas.

helped shape western medicine. About five centuries after the oath was discovered in Alexandria and two centuries after the birth of Christ, Galen's teachings and influence emerged and remained dominant until the 19th century.[6]

Today, we expect physicians to be responsible for instructing the next generation of physicians in the moral and ethical obligations to their patients and society. Symbolically the Staff of Asclepius which dates back to antiquity represents those qualities desired in physicians.Included among those qualities are: respect for patients regardless of social status; personal attributes such as truthfulness, compassion, kindness and thoughtfulness; appropriate training and experience to design and analyze evaluations for diagnosis; use of the latest effective treatment; concern for the patient's general welfare, willingness to consult with other physicians as necessary; and assurance of confidentiality.

Today, we expect physicians to be responsible for instructing the next generation of physicians in the moral and ethical obligations to their patients and society.

We have many symbols in our culture and individually each of us has perceptions of what these represent. Diversity of culture and background cause variations in the representations; however, most physicians' beliefs and practices are similar. All physicians remain concerned about ethic considerations in their practices. Since the beginnings of medical ethics were with Asclepius, it is fitting to review the evolution of the meaning of the symbol which is widely used today.

The Staff of Asclepius as the symbol for medicine had its origins more than 35 centuries ago when in 1405 B.C. Asclepius entered the profession. Therefore, the practice of medicine by priest-physicians had its origin in the personage, Asclepius, before the birth of philosophy. [7] Asclepius was from Epidaurus in southern Greece and the inference from Homer is that he was human. Homer indicated in the Iliad that Machaon was the son of Asclepius and apparently not the son of a god.[8] Machaon was summoned to treat the King's bleeding wounds and was recognized as a surgeon. Treatment involved sucking out the blood and putting on a plaster of soothing drugs provided by Chiron, the centaur. This treatment provided during the Trojan Wars was done by a son of Asclepius before he was deified. Asclepius had another son, Podalirius, who also served as a physician in the Trojan Wars. Following the Trojan wars, for several centuries Asclepia, temples of health presided over by Asclepiads, were erected throughout Greece to receive the sick for treatment.[9]

Greek legends link Asclepius to Apollo, who has been depicted as the

founder of the art of medicine. According to legend, Asclepius was the son of Apollo and Coronis, daughter of Phlegyas.[10]

A raven, given to Coronis as a guardian during her pregnancy by Apollo, revealed to him that Coronis had committed adultery and consequently became permanently black instead of white. Coronis was slain with arrows by Apollo who removed Asclepius from her womb. Chiron, a centaur, who excelled in knowledge, taught Asclepius how to cure diseases.[11] The name, Asclepius, means deferring the withering that comes with death and healing soothingly.

Asclepius had many children. In addition to the two physician sons, Podalirius and Machaon, there were the daughters Panaceia and Hygieia.[12] Panacea means all-healer from a root discovered by Asclepius, found to be effective for inflamed conditions and other symptoms. Hygieia became goddess of health and preventive medicine. Asclepius has been credited with developing the art of medicine and surgery including bedside medicine, restoring life, devising remedies and salves, using herbs, applying bandages, and others. The reputation of Asclepius became enhanced as he apparently cured the sick contrary to expectations and even revived those who had died.[13] Zeus became angered and struck Asclepius with a thunderbolt and killed him because the number who were dying was decreasing and thus would result in over population. But whether Asclepius was a man or god from the outset, he became a very important mythological symbol of healing. The Greeks were known to include in their gods those who had accomplished something or acted nobly or bravely in battle. Therefore, Asclepius could have been addressed as a god after his death.

Statues of Asclepius showed him as a god, seated on a throne holding a staff. The staff was seen as a sign of support and also a symbol of relief for invalids. The staff is presented gnarled which signifies the difficulty of the art of medicine. One of the more famous statues of Asclepius was at Epidaurus where the image was made of ivory and gold depicting him seated on a throne grasping a staff in one hand and placing the other hand over the head of a snake and a dog lying by his side .[14] Another statue showed the snake twinned about the staff. The snake is a symbol of perennial youth for the serpent is said to shed old age and grow young again. Since Asclepius renewed the human body by his medical skill, then there was association with the snake. The snake, vigilant with keen vision, has also been considered a sign of attention which is required in medicine. A snake, *Elaphe longissima* of a peculiar yellow color, crawled into a Roman boat in Epidaurus, and it was perceived that the god himself was in the snake, for a pestilence of three years was dispelled at Tiber where the boat landed.[15, 16] Summarily, the serpent exemplifies the attention required in

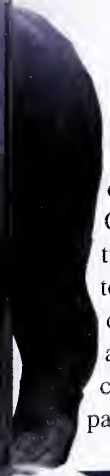
Continued on page 32

M=DI

Editor's Note: *Following is the transcipt of a speech given by Robert Moffit, Ph.D. at MASA's Leadership Conference earlier this year. Moffit is the Deputy Director of Domestic Policy with the Heritage Foundation, a non-partisan think tank based in Washington, D.C. The following has been edited due to space considerations. For a complete tape of the speech, contact MASA at 1-800-239-6272.*

I should tell you that before I was an officer in the Reagan administration, I was an idealist. Most of you are laughing, but I think most of you don't really know what an idealist is. There was once a great speaker of the House of Representatives from the state of Texas that I am sure many of you would remember, the great, late Sam Rayburn. Sam Rayburn once said that an idealist is kind of an enthusiastic young fellow who comes to Washington and gets rained on a lot — only he didn't exactly use the word "rained." I have been asked to talk about rain. The Medicare system.

Let me just ask you to exercise your imagination for a moment. I just want you to consider the hippopotamus. It's a huge fat ugly beast. Giant creatures who wade deeply into tropical ponds munching tons of leaves and water lilies. A ravenous appetite for lush greenery is seemingly endless



and whose attitude towards other smaller creatures in God's creation bears a disturbingly strong resemblance to human indifference. In any case, the hippo looks and acts, at least to ordinary folks, as a creature whose responses are painfully, even agonizingly

RE

slow. That's a common perception, but imagine we're wrong. We're not only unkind, but also unjust in our assessments of the hippopotamus. Imagine instead that the hippopotamus has powerful admirers and they are legion. They boldly assert that the hippo is in fact given to great dexterity. They marvel at its lightening speed and the agility of the great beast. Yet others celebrate its marvelous capacity for high jumps.

Others look beyond its great and bulbous head and rotund torso and see only sleek lines, a figure of incomparable grace and beauty. Others sternly insist that with the right training and proper patience the beast can be taught ballet. They envision the hippo spinning a pirouette to the deafening applause of millions. And ballet promotion programs for hippopotami become the national rage.

The American Association of Retired Admirers of Hippopotami are not to be trifled with by anyone, especially members of Congress. And they feverishly disseminate all sorts of remarkable information about the beauty and physical dexterity of the great beast.

Yet some of us remain unconvinced. We know the hippopotamus does many, many things very well. Most impressively it eats leaves, but we harbor doubts about its grace, agility and dexterity. We even whisper in corners that we doubt its beauty and its future potential for performing ballet.

We think, upon reflection, that it rather looks and acts like the mammalian equivalent of the Medicare bureaucracy. It eats tons of lush green, young, freshly minted dollars. It relentlessly deforests the national treasury. It gets larger and larger and moves slower and slower and has all the congeniality, the diplomacy and the imagination of a regulatory guideline solemnly promulgated by the Health Care Financing Administration.

Hippos may be ugly, but HCFA is obnoxious.

In 1997, the Congress of

the United States and the President passed the 1997 Balanced Budget Act, which President Clinton described as the achievement of a generation — kind of shrinking national achievements. The BBA seeks a Medicare reduction over the next five years of 115 billion bucks — 385 billion bucks over the next ten years. Grown ups know that this is not any kind of serious attempt at controlling the Medicare program for the future or making it better.

Apologists for the current system in Congress and elsewhere praise it as a model of administrative efficiency, which is true, if and only if you are prepared to break diplomatic relations with reality.

According to the Progressive Policy Institute, which is a moderate democratic think tank in Washington, Medicare is governed by at least 22,000 pages of rules, regulations and guidelines. An amount that is growing rapidly.

Apologists for the current system in Congress and elsewhere praise it as a model of administrative efficiency, which is true, if and only if you are prepared to break diplomatic relations with reality. The reality is that doctors, hospitals and patients are drowning in a sea of Medicare paper work. According to the American Medical Association, doctors today spend an estimated 25% of their time complying with the blizzard of Medicare paper work. A survey of physicians conducted by the Physician Payment Review Commission (PPRC) shows that 7 out of 10 doctors say the hassle factor in Medicare, is driving them nuts. Medicare is perceived to be worse than any other program including Medicaid and even some obnoxious managed care plans.

Medicare sets benefits by law and regulation so if you are a patient and you are trying to get coverage it all depends on what the law and regulation says. If you're trying to get coverage for a medical technology, or you want a medical device covered by Medicare, the decision will depend upon a little sub-unit called the technical advisory committee. I'm sure some of you have had some dealings with them. They meet in secret and report to HCFA, which in turn decides what medical technologies will and will not be available to the American people. The long established clandestine practice is in flat out violation of federal law. The General Accounting Office (GAO) just recently reported to Congress that this entire process is illegal. The GAO says that these kind of decisions should be under the Federal Advisory Committee Act, which means that because they affect the well being of 257 million Americans that the meetings should be open.

The GAO, the investigatory agency in Congress, in a major 1994 study on Medicare's benefit setting, reported that simple decisions to extend coverage for medical treatment takes anywhere between two

months and twelve months, depending on the condition. If the treatment is more complicated it could take several years.

For doctors, the situation is getting tricky. As Dr. Philip Alford, an internist specializing in geriatrics, wrote recently in the Nov. 5th edition of *The Wall St. Journal*, "If a doctor orders a stool specimen to test for occult blood which might indicate an early colon cancer, is he engaging in a good medical practice or criminal behavior? Answer: it depends. If the patient doesn't have any symptoms and the bill is sent to Medicare, it is a criminal offense because these preventive services are not covered benefits, thus billing them to Medicare is considered fraud. The absence of intent to cheat Medicare doesn't matter. Fines of up to $10,000 per incident may be levied on the physician who simply orders the test from a lab at no personal profit."

This is not a case of public policy. This is not a question about a good idea and a bad idea or a real debate about what is right and what's wrong. This is absurd. It is crazy.

For patients the situation is getting tricky, too. If for any reason a patient wants to make a private agreement with a doctor for a service that is covered by Medicare, he can do so. But under the terms of section 4507 of the Balanced Budget Act, the doctor has to sign an affidavit to that effect and drop out of Medicare for a period of two years.

Now this statutory obstacle to private agreements between doctors and patients is found under no other government insurance program, including that which covers Congress. A physician could not treat his mother for an apple pie and a kiss without being in violation of the law. This official bipartisan stupidity is utterly unique. Nothing like it any place else.

In terms of pricing, the bureaucratic beast is inflexible. One of the things I do that most Congressmen do not, is that I read the General Accounting Office reports. If you look at recent GAO reports on the subject of Medicare's pricing schemes for doctors and hospitals, they are incredibly complex and they are bizarre, but the GAO's reports on this are very instructive. The GAO

As a healthcare provider, your time is precious.

Your patients and your practice are your top concerns.

PrimeCare Patient Management System
can help you maximize your time, improve the quality of patient care and increase your returns by providing:

- Increased Documentation
- Detailed Electronic Patient Charting
- Easy Access to Patient Information
- Patient Education Materials
- Computer-conducted Patient Subjective Interviews
- Prescription Printing
- Automatic Drug Interaction Checking *and much more!*

The clock is ticking, don't let another minute go by-
PrimeCare Patient Management System
can interface with most billing software systems with minimal or no cost to you.

1-800-590-3224

For further information, please contact:
Crest Health Systems, Inc.,
Melissa N. Sites
FAX: 850-769-9747

reports Medicare always pays too much, or they pay too little, or they don't have enough data, or they didn't take into account the right factors, or there are not enough factors to make a proper decision about how something should be reimbursed.

So modifying or reconfiguring the drg's or the resource based relative value scale, which is something that was smuggled from East Germany on the last train out, is perhaps the best justification for lifetime employment at the Health Care Financing Administration. In other words, the GAO says they never get it right. Why don't they get it right? You know why they don't get it right. Because administrative pricing is never right. It is either too high or too low, it is never right. What is the right price? The right price, as you all learned in Economics 101, is where the supply curve has a tryst with the demand curve on the blackboard with a little x and they meet in private and determine what the price is. HCFA can't do that. HHS has recently determined that Medicare pays substantially more than market prices for inpatient drugs and medical equipment. In a study of 22 common drugs, the federal government recently found they paid more than double the average wholesale price and, in one case, ten times the average price for these drugs.

HHS secretary Donna Shalala, in the Washington Post she says, "We're over-paying for almost everything because we are locked into a pricing structure."

Donna can be taught. Even when Medicare tried to get it right, be modern and up-to-date, HCFA looks kind of like an old fashioned Soviet factory management team, desperately trying to catch up with the West, replicating the latest technology hijacked from the United States. In the private sector people move quickly. Not in Medicare. Medicare has been screwing around with managed care since 1983. I think they have about eight and a half or nine percent of the medical Medicare population in managed care.

Senator John Breaux, Louisiana Democrat, notes that the federal government today is the only institution in the entire cosmos that can manage to lose money on HMOs.

Helen's
Computer Services Unlimited
HELEN ALEXANDER
Service: 334-567-4497
General Data Entry
Electronic Insurance Claims
Standard HCFA - 1500 Format
Pick-up and Delivery Service Available

Now if you think about this stuff it's funny, but it is funny because the policies are so absurd.

Some people in Congress say it will be a bad thing for the elderly if we change Medicare, but I assure you ladies and gentlemen, it will be a disaster for everyone, including the elderly, if we don't. The problem is that like the health care system in general, most of the American people still don't understand it. Let me give you some revealing information. In a survey conducted by the Kaiser Family Foundation and Harvard University, 58% of all Americans said that more is spent on foreign aid than Medicare. Only 27% got it right. Only 15% had the good sense to say that they didn't have a clue. People don't understand this.

...58% of all Americans said that more is spent on foreign aid than Medicare. Only 27% got it right. Only 15% had the good sense to say that they didn't have a clue. People don't understand this.

During the debate on the Clinton plan a few years ago we had these town hall meetings all around the country. Members of Congress summoned up the courage to walk into high school auditoriums and have these discussions. There was a congressman in California who had one of these meetings and there was a woman in the back of the room that was flushed. She was angry. She was obviously very upset. She was breathing heavily and she finally had a chance to make her statement. She went to the microphone at the back of the hall and she said she didn't want her congressman voting for that Hillary plan, and then she said that the last thing she wanted was the government taking over Medicare.

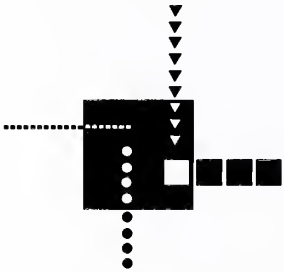
Only one in five Americans, according to the same survey, knows the difference between Medicare and Medicaid. It's the least favored entitlement program for any kind of reduction. And of course, senior citizens are absolutely convinced that they paid for their benefits. This is confirmed in other surveys. There was a survey conducted by the American Hospital Association that reported that 67% of all seniors and 58% of all voters think that Medicare is a benefit that they have already paid for. This entitles them to membership in the equivalent of the flat earth society.

As the former HCFA actuary Guy King told Congress, for every one dollar spent by the elderly on Medicare, the taxpayer is kicking in five bucks. The pattern will accelerate. And how will it accelerate? Well, it will accelerate very quickly in the next few years.

According to the non-partisan Committee for Economic Development, if changes aren't made, combined Social Security and

Continued on page 37

Your Success is Our Goal



American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
Sheraton Chicago Hotel and Towers
Chicago, Illinois

To succeed in today's health care environment, your medical staff needs the latest information and appropriate skills for meeting the day-to-day challenges of medical practice. By attending this meeting, you can learn about:

- **Managing physician organizations**
- **Negotiating and resolving conflicts**
- **Helping and handling the disruptive physician**
- **Emerging information technology**
- **Capitation**
- **Stark II recommendations**
- **Antitrust**
- **Organized medical staff challenges in the future**
- **Effectively communicating in business practice**
- **PSOs and Medicare risk contracting**
- **Unionizing**
- **E/M Documentation Guidelines**

In addition to these educational offerings, as an AMA-OMSS representative of your medical staff, you can participate in advocacy, policy-making and networking activities. **Our goal is to work with you to identify and address medicine's most pressing issues. We also want to help you increase your knowledge and skill so that together we can best serve the needs of patients, physicians, and the profession.**

To achieve this goal you can:

- Submit resolutions and participate in mode-of-practice and general interest forums to bring your concerns to the forefront.
- Testify at reference committee hearings and vote on actions in a democratic assembly to further AMA's advocacy agenda.
- Attend practical education programs to improve your medical practice, earn **8.5** hours of CME credit** and pay no fee to register!

Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association
Physicians dedicated to the health of America

Across This Doctor's Horizons: My Own Mission Field

by James F. Crenshaw, M.D.
James F. Crenshaw, M.D. 1995
ISBN 0-87651-937-0
164 pages.

Dr. Crenshaw has written an autobiography of his sojourn as a physician with particular focus on his religious beliefs.

His life has been successful and fulfilling across a wide range of challenges. He shares his experiences and the tools he employs to master the tasks at hand. He accepts responsibility for his life and recommends that others do the same.

Danger and adversity are seen as opportunities to build character. Boundaries are necessary in all human relationships. He believes in absolutes, clear rights and wrongs. There are discourses ranging from "Stress" to "Salvation".

His style is folksy, conversational. There are a plethora of opinions and there is no backing away from controversy. One does not have to agree with all his opinions to admire his firmness and resolve. Throughout the book, I felt that if I sat down with Dr. Crenshaw, we would have a good time discussing our differences, that we would learn from each other with both of us coming out the wiser. Learning can only be accomplished by exploration.

Too often in our modern world, people do not wish to take a firm stand on the great issues confronting us. A confluence of proprietary ethics and a cult of narcism have permeated modern medicine. The strong characters of medicine have fallen by the wayside.

I want to practice with men and women I respect and admire. Capable physicians with strong personalities disagreeing with each other in a never ending search for the truth will best serve our patients, which is the singular call made of our profession. We thank Dr. Crenshaw for taking the time to write this book. ★

Reviewed by David W. Hodo, M.D., Book Editor

If you are interested in reviewing a book or know of a book you think should be reviewed, contact Dr. Hodo at (334)872-6773. The *MASA Review* is particularly interested in books by Alabamians or about Alabamians.

Physician Assistants and Alabama Physicians: A PROGRESSIVE HEALTH CARE PARADIGM

By George White, Jr., PA-C, MSPH, Ph.D.
Daniel T. Vetrosky, PA-C, M.Ed.
Richard O. Nenstiel, PA-C, MBA
Richard H. Esham, MD, FACP

Physician assistants (PAs) are physician dependent medical practitioners. They are authorized by individual states and/or the federal government to provide medical care with the supervision of a licensed physician. PA enabling legislation has been passed in all U.S. territories and 49 states (Mississippi being the lone exception). Alabama legislation clearly stipulates the Board of Medical Examiners "shall have and exercise all powers related to the regulation of physician assistants within the State of Alabama."[1] PAs are certified to practice in Alabama through an application process involving the Alabama Board of Medical Examiners, the supervising physician, and the PA. The Alabama Board of Medical Examiners determines appropriate PA utilization. The law clearly stipulates that professional oversight and direction must emanate from the physician supervisor. PAs and their supervising physician are responsible for maintaining certification on an annual basis through the Alabama State Board of Medical Examiners. The physician-dependent role affords PAs a large amount of responsibility for patient care without diminishing the authority and control of physicians.

It is estimated that 28.9 percent of Alabama's population live in feder-

ally designated primary care shortage areas. The population to physician ratio for this subset of Alabama citizens is 4552:1. The national standard for designation as a primary care shortage area is 3500:1.[2] These factors help explain why many Alabamians lack access to primary health care. This problem is neither unique to Alabama, nor is it newly understood. In the mid-1960's, a group of North Carolina physicians and educators recognized the need to increase the number of health care practitioners who would provide care in medically underserved areas. Their solution was the development of a new health care professional known as a physician assistant who would work with physicians to improve access to quality health care.

History of the Profession

The concept that ultimately matured into the physician assistant profession was originally proposed by Dr. Charles L. Hudson in the *Journal of the American Medical Association* in 1961.[3] Dr. Hudson proposed the training of non-physician clinicians who could play an intermediate role between a technician and physician who "...could not only handle technical procedures but also take some degree of medical responsibility."[3] By the mid-1960's, Dr. Eugene A. Stead, Jr., Chairman of the Department of Medicine at the Duke University Medical Center, brought this idea to fruition by training "physician's assistants" in the medical model. He originally proposed the training of clinical nurses in an abbreviated course of medical instruction. The National League of Nursing refused to support this plan which prompted Dr. Stead to turn to former military corpsmen as a source of personnel.[4] His first class of five students graduated from the Duke University Physician Assistant Program in 1967. From this humble beginning the profession has grown to approximately 31,000 PAs in clinical practice. PA programs are accredited by the Commission on Accreditation of Allied Health Education Programs. Presently there are 96 such programs in the United States. They are located at medical colleges, universities, and teaching hospitals. Upon graduation from an accredited program, PAs must pass and maintain national certification. Maintaining national certification requires a PA to complete 100 hours of continuing medical education (40 of which must be category 1) every 2 years and pass a recertification examination every 6 years. Today a typical PA student has a B.S. degree and four years of health care experience. Although ex-corpsmen continue to be represented in the PA student population, their numbers have gradually declined over the past 15 years. Now a variety of allied health professions are represented in a typical class, i.e. nurses, pharmacists, physical therapists, respiratory therapists, exercise physiologists, x-ray technologists, athletic trainers, etc.

Alabama first recognized the ability of PAs to extend primary care physician services to underserved

populations in the early 1970s. For the past eight years the State Health Planning Agency has advocated the increased training and utilization of mid-level primary health care providers, such as physician assistants (PA).[5] A 24 month bachelors level primary care PA program was opened at the University of Alabama at Birmingham (UAB) in 1970 and closed in 1976 after graduating 104 students. Also between 1971-72, 21 students completed a federally funded 12 month certificate PA program (MEDEX). UAB has operated a very successful bachelors degree surgical PA program since 1967.[6]

Despite these efforts, utilization of PAs in Alabama has been minimal (approximately 160 practicing/registered.) In 1994, with the strong support of the Medical Association of the State of Alabama (MASA), significant changes were made in existing PA legislation, which encouraged the University of South Alabama to take the lead in establishing Alabama's first Master's level primary care physician assistant program in 1995. The University of South Alabama Physician Assistant program is a very concentrated 27 months of study, similar to the first and third years of medical school. While the first four semesters are composed of classroom instruction in medical sciences, the three semester second phase is devoted to hands-on clinical experience in primary care, as well as various medical specialties. The basic prerequisites for application are a B.S. degree with at least a 3.0 GPA, and official Graduate Record Examination (GRE) scores not older than 5 years.

PA Capabilities and Utilization

The academic standards for the education of physician assistants are based upon The Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician.[7] This document has been developed under the administrative control of the Commission on Accreditation of Allied Health Education Programs and with the collaboration of the American Medical Association, the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, the American Society of Internal Medicine, and the American Academy of Physician Assistants. These Essentials stipulate the capabilities and functions as follows:

The fundamental tenet of the PA profession is the dependent relationship that binds the PA with the supervising physician.

Physician assistants are academically prepared to provide health care services with the direction and

responsible supervision of a doctor of medicine or osteopathy. The functions of the physician assistant include performing diagnostic, therapeutic, preventive and health maintenance services in any setting in which the physician renders care, in order to allow more effective and focused application of the physician's particular knowledge.[7]

Supervision

The subject of supervision and the dependent nature of PA practice requires a clear understanding in the context of midlevel providers. There are fundamental differences in philosophy, training, and regulation between PAs and nurse practitioners (NPs). Physician assistants do not practice independently; this is inherent in the philosophy of the profession and is enforced by state law. The fundamental tenet of the PA profession is the dependent relationship that binds the PA with the supervising physician. This relationship begins in PA school where physicians provide the majority of instruction in a curriculum following the medical school model. Also, PA students perform clinical rotations with medical students and residents. Consequently, physicians and PAs develop a homogeneity regarding medical reasoning. Dependent practice continually refines the PA's ability to reflect the supervising physician's expertise.

Very few NP programs utilize core faculty members from disciplines other than nursing, and most offer significantly less clinical training than PA programs.[8] NPs are regulated by State Boards of Nursing and function under State Nurse Practice Acts. (In Alabama, NPs are co-regulated by the Board of Medical Examiners and the State Nursing Board.) In 49 states physician assistants are regulated by state law that gives either the Board of Medical Examiners or a similar entity administrative authority over physician assistants.

Conclusion

The basic premise of the PA profession is the dependent relationship that binds the PA with a supervising physician. PAs are educated and regulated by physicians. The documented success of physician/PA teams in extending access to quality health care is a perfect match for the Alabama medical care paradigm. ✦

George L. White Jr., PA-C, MSPH, Ph.D. is professor and chair of the Department of Physician Assistant Studies at the University of South Alabama. He received his physician assistant training, Masters degree in public health and a doctorate in health education from the University of Utah.

Daniel T. Vetrosky, PA-C, M.Ed. is Assistant Professor and Academic Coordinator of the Department of Physician Assistant Studies at the University of South Alabama. Mr. Vetrosky is a 1981 graduate of the Duke University PA program and

received a M.Ed. in health services education from Augusta College in 1990.

Richard O. Nenstiel, PA-C, MBA is Assistant Professor and Clinical Coordinator in the Department of Physician Assistant Studies at the University of South Alabama. Mr. Nenstiel is a 1978 graduate of Pennsylvania State University (Biology) and a 1980 graduate of the Surgical Physician Assistant Program at the University of Alabama-Birmingham and received an MBA from the University of South Alabama in 1988.

Richard H. Esham, MD, FACP is Professor of Medicine in the College of Medicine, University of South Alabama, Past Chairman of the Board of Censors of the Medical Association, State of Alabama, and Past Chairman of the Alabama Board of Medical Examiners. He received his medical degree from the University of Louisville in 1967. Dr. Esham serves as Medical Director of the Physician Assistant Program at the University of South Alabama.

References

1. Alabama Code §§ 34-24-290 to 293 (Supp. 1994) (Amending Ala. Code §§ 34-24-290 to 293 (1975).
2. BHCDANET Information System, Health Professional Shortage Areas Basic Listing, State of Alabama 1997, Division of Shortage Designation, U. S. Public Health Service.
3. Hudson CL: Expansion of medical professional services with non-professional personnel. JAMA 1961;176:839-841.
4. Stead EA: Training and use of paramedical personnel. N Engl J Med 1967;277:800-802.
5. Alabama State Health Plan 1996-1999, State Health Planning and Development Agency, page 15-17; Alabama State Health Plan 1992-1995, State Health Planning and Development Agency, pages 13, 15, 16.
6. Personal communication, October 30, 1997, Ms. Carol E. Medders, Manager of Academic Data and Analysis, School of Health Related Professions, University of Alabama, Birmingham (UAB).
7. Commission on Accreditation of Allied Health Education Programs, Standards and Guidelines for an Accredited Educational Program for the Physician Assistant (Adopted 1971; revised in 1978, 1985, 1990 and 1997).
8. Fowkes VK, Gamel NN, Wilson SR, et al: Effectiveness of educational strategies preparing physician assistants, nurse practitioners, and certified nurse-midwives for underserved areas. Public Health Reports 1994;109(5):673-82.

ADVERTISER INDEX

Mutual Assurance
Inside Cover
Crest Health Systems, Inc.
Page 11
Helen's Computer Services
Page 12
AMA-OMSS
Page 14

masa services

THIRD PARTY TASK FORCE

The Third Party Task Force is a committee of MASA which consists of physician members who provide assistance to other physicians in resolving issues and disputes with insurance companies, HMOs, other third party payors, including Medicaid and Medicare, and other peer review organizations. Member physicians requiring the assistance of the Task Force should send a letter detailing the nature of the dispute and copies of relevant correspondence or medical records to MASA. *Contoct: Wendell Morgan 1-800-239-6272*

PHYSICIANS RECOVERY NETWORK

The Physicians Recovery Network promotes the early identification, evaluation, and treatment of physicians who may be impaired as a result of mental/emotional illness, or substance abuse/dependence. A documented program of recovery is offered to enable these physicians to return to practice. The PRN staff is available to present several educational programs suitable for all audiences. *Contoct: Jerry Summer, M.D., 1-800-239-6272*

COLLECTION AGENCY

One of the biggest problems for physicians is collecting fees owed to them by patients. Keeping costs down and cash flowing are critical factors in the success of any practice—fiscal soundness is a must, and physicians need an effective collection agency to assist them in recovering delinquent accounts such as I.C. Systems, Inc. *Contact: I.C. Systems, Inc. 1-800-685-0595*

GOLD MASTER CARD PROGRAM

Your MASA membership entitles you to participate in this outstanding credit card program, featuring a credit line up to $15,000, no first year annual fee and an annual fee of only $30 after the first year. *Contoct: MBNA 1-800-847-7378 Ext. 400*

MAGAZINE SUBSCRIPTION PROGRAM

MASA members can take advantage of low subscription rates for a tremendous array of popular and specialty magazine, which include *TIME, The New Yorker, US. News & World Report, Vonity Fair,* and *Better Homes ond Gorden. Contoct: Subscription Services, Inc. 1-800-289-6247*

TRAVEL AND HOTELS

MASA has made arrangements with Destinations Quest International Hotel Savings Program to enable you to enjoy savings of up to 50% off standard hotel rates and up to 25% discount on many hotel restaurants at more than 2,100 top quality hotels. *Contoct: MASA 1-800-239-6272*

LONG DISTANCE TELEPHONE SERVICE

DeltaCom was chosen to offer a program to physicians because of their commitment to personalized customer service, simplicity of billing statements, as well as DeltaCom's unique ability to customize business long distance accounts. *Contact: DeltoCom 1-800-239-3719*

TAX AUDIT DEFENSE

TaxResources, Inc., the pioneer and largest Tax Audit Defense firm in the U.S. brings to our Association physician members the specialized abilities of over 500 hand picked and specifically trained IRS agents, auditors, and tax attorneys. *Contact: ToxResources, Inc. 1-800-922-8348*

PROFESSIONAL LIABILITY AND OTHER TYPES OF INSURANCE COVERAGE

Coverage is available through Mutual Assurance, Inc. of Birmingham, the largest writer of liability insurance for physicians in the state. Mutual Assurance was formed by MASA during the insurance crisis of the mid 1970's, when liability coverage was suddenly not available to Alabama physicians. Mutual Assurance, Inc. also offers other types of insurance coverage such as disability, life, business overhead. *Contoct: Mutuol Assurance, Inc. 1-800-282-6242*

HEALTH INSURANCE COVERAGE

MASA endorses Blue Cross Blue Shield group health insurance plans for you and your staff.
Contoct: Emmett Wyott, MASA 1-800-239-6272

PRACTICE MANAGEMENT RESOURCES

United Communications Group offers newsletters and other publications to help physicians, including: Part B News, Part B Answer Book, Practice Strategies for Managed Care, Physician Practice Coder, RBRVS FeeCalc software, Medicare Compliance Alert and Physician Office Lab News. Exclusive MASA discount available.
Contoct: United Communicotion Group, 1-800-929-4824, Ext. 2238

SCIENCE or SNAKE OIL

By Judy Burnham, MLS, AHIP
Biomedical Library
University of South Alabama

Evaluating WWW Sites on the Internet

The seemingly limitless amount of medical information has made sifting through it a Herculean task and often it is hard to tell the difference between the "science and the snake oil."[1] Individuals are faced with a plethora of electronic information via the Internet.

There is a lack of standards or quality control on the Internet. Because of this deficiency control, World Wide Web (WWW) sites are not peer reviewed, like many journals. Almost anyone can publish information on the WWW. All that is needed is a computer, appropriate software (which can be downloaded free from the Internet) and server storage space, which many Internet Service Providers make available. The user has to be aware of this fact and be able to discern the science from the snake oil. This is especially important for physicians who must not only evaluate web sites for themselves, but also be able to help their patients interpret the information as well.

It is often difficult to determine the author or publisher of a web page, and even if an author's name is given, their credentials or qualifications usually are not. Even if the web page is located on a server at a university, the author may be a student rather than a professor.

An analyses 160 randomly-selected consumer-oriented, health and medical information web sites revealed that "more than half of the sites are owned by organizations or individuals who may be providing biased or inaccurate information."[2] Impicciatore, et al. analyzed 41 web pages that covered managing fever in children at home. Only a few web sites provided complete and accurate information for treatment of this condition. The authors note that "this suggests an urgent need to check public oriented healthcare information on the Internet for accuracy, completeness, and consistency."[3] With print sources, such as journals, there is a clear distinction between advertising and information, but this distinction is not clear on the WWW. A great deal of marketing takes place via the Internet. While commercial sites may provide valid information, the user needs to be aware of possible biases.

Keep in mind that the number of awards showing on a web page is not an indication of the quality of the information. Some awards are legitimate, but others are not.

There are questions that can be asked when viewing a WWW site that will reveal the reliability of that site. There are five major areas of concern: accuracy, authority, objectivity, currency, and coverage. The questions to ask in each area are:

1. Accuracy

* What is the author's authority?
* Can information be verified?
* Is the document free of errors?

2. Authority

* Is the author recognized and well regarded in field?
* Is information from edu (education) server? (Educational servers

are located at universities; other server domains include com-commercial, org-organization, gov-government) what is the author's relationship? (WWW page may be mounted by student at that site).
* Who is the publisher of the web page?
* Were you referred to the site by reliable source?
* Is the information referenced?
* Is the author's e-mail address published?

3. Objectivity
* Is any sort of bias evident?
* What is the purpose of the page?
* Is it clear who is responsible for the material?

4. Currency
* Is the web page clearly dated as to when it was written?
* Is the date of revision stated?
* Is the date of any data presented clearly given?
* How often is the web page updated?

5. Coverage
* Is coverage complete for topic and audience?
* Is the web page part or entirety of work?
* Is the page still under construction?
* What topics are included? Which topics are explored in depth?
* If also available in print, is coverage on WWW site different?
* Is the information new or unique?
The best sources of reliable web pages are colleagues, articles and peer-reviewed health sites. A list of peer-reviewed health sites is listed below:

Medical Matrix
http://www.medmatrix. org/Index.asp

Six Senses
http://www. sixsenses. com/

Physicians Choice
http://www.mdchoice.com/ ★

References

1. Silberg WM, Lundberg GD, Musacchio RA. Assessing, controlling and assuring the quality of medical information on the Internet: Caveant Lector et Viewor — Let the reader and viewer beware. JAMA 277(15): 1244-45, April 16, 1997.

2. Consumer Health and Medical Information on the Internet: Supply and Demand: The Supply: An Overview of Health and Medical Information Resources on the Internet. http://etrg.findsvp.com/health/mktginfo.html [Site viewed 1/20/98; Site last updated 12/97]

3. Impicciatore P. Pandolfini C, Casella N. Bonati M. Reliability of health information for the public on the world wide web: systematic survey of advice on managing fever in children at home. BMJ 1997 Jun 28; 314(7098): 1875-1879

WWW Sites with Information on Evaluation

Alexander J. Tate M. Evaluating web resources. http://www.science.widener.edu/~withers/webeval.htm. [Site viewed 1/20/98; Site last updated 5/30/97]

Grassian, E. Thinking critically about World Wide Web resources. http://www.library.ucla.edu/libraries/college/instruct/critical.htm.[Site viewed 1/20/98; Site last updated 11/5/97]

Janicke, L. Resource selection and information evaluation http://alexia.lis.uiuc.edu/~janicke/Evaluate.html. [Site viewed 1/20/98; Site last updated 5/29/97]

Scholz, A. Evaluating World Wide Web information http: //thorplus. lib.purdue.edu/research/classes/gsl75/3gsl75/evaluation.html [Site viewed 1/20/98; Site last updated 2/96]

Schrock, K. (Ed.). Kathy Schrock's Guide for Educators: Critical Evaluations Surveys. http://www.capecod.net/schrockguide/eval.htm [Site viewed 1/20/98; Site last updated 7/21/97]

Tillman, H. N. Evaluating quality on the net. http://www.tiac.net/users/hope/findqual.html [Site viewed 1/20/98; Site last updated 11/13/97]

Traditi L, Walsh M. The Internet and the world wide web. http://www.uchsc.edu/library/webclass3.html. [Site viewed 1/20/98; Site last date updated 12/14/97.]

INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper. Manuscripts may be mailed, faxed or e-mailed to the address below. (E-mail is preferred method.) Authority for approval of all contributions rests with the Editor. *MASA Review* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

Style: The first page should list title, the author(s), degrees and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month - day of month if weekly - and year. References should be numbered consecutively in order in which they appear in the text. *The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style.

Length of Articles: Articles should not exceed 10 printed pages.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

MASA Review
Attn: Amanda Jones
P.O. Box 1900
Montgomery, AL 36102-1900
1-800-239-6272 phone
1-334-269-5200 fax
amanda@masalink.org

upcomi

APRIL

April 21-23
Alliance Annual Meeting
Embassy Suites
Montgomery, Alabama
Contact: Frankie Armstrong, 1-800-239-6272

April 22-25
Pediatrics Update
Hilton Head Island SC
Contact: George M. Converse, MD Lloyd Noland Foundation (205) 783-5276
CME Credit: 15 hours of Category 1

April 23
1998 Loss Prevention Seminar Communicate Your Way to Effective Patient Relationships
Anniston AL
Contact: Mutual Assurance
1-800- 282-6242 or (205)877-4400
CME Credit: 2 hours of Category 1

April 25-28
62nd Annual SE Section Urological Assoc.
Birmingham AL
Contact: William Brannan MD, (504) 624-9998
CME Credit: TBA

April 26
AL Chapter Amer. College of OB/GYN
Destin, FL
1998 Loss Prevention Seminar - Communicate Your Way to Effective Patient Relationships
Contact: Mutual Assurance, 1-800-282-6242 or Judy Lovelady, ACOG, 1-800-239-6272
CME Credit: 2 hours of Category 1

April 30
Net Rx: Internet Overview for the Health Professional
Auburn, AL
Contact: Tammy Lee (334)844-1749
CME Credit: 4 hours of Category 1

MAY

May 1-3
Spring Seminar 98, "Diabetes, Metabolic & Cardiovascular Disorders"
Guntersville AL
Dr. David Haigler (205) 502-6358
CME Credit: 8 hours Category 1

May 2
Birmingham AL
Derby Day Topics in Medicine
Contact: Annette Lee 205-877-1692
CME Credit: 6 hours Category 1

May 6
MASA Third District Caucus
Alexander City, AL
Willow Point Country Club - 7 p.m.

May 7
MASA Sixth District Caucus
Birmingham, AL
Jefferson County Medical Society - 6:30 p.m.

May 7-9
15th Annual Review of Modern Therapeutics
Huntsville, AL
Contact: UASOM/Huntsville - Office of CME (205) 551-4490
CME Credit: 15 hours Category 1

May 7
AL Chapter, American College of Surgeons
Point Clear, AL
Communicate Your Way to Effective Patient Relationships
Contact: Mutual Assurance, 1-800-282-6242 or John Hooten, ACS, (205)930-8710
CME Credit: 2 hours of Category 1

May 13
MASA Second District Caucus
Troy, AL
Holiday Inn - 6 p.m.

May 14
Practical Day of Pediatrics
Birmingham, AL
Contact: Mardi Morard Trimble, Children's Hospital (205) 939-9898
CME Credit: TBA

May 14
MASA Seventh District Caucus
Tuscaloosa, AL
DCH Regional Medical Center - 6:30 p.m

events

May 16
MASA Fourth District Caucus
Gadsden, AL
Red Lobster - 12 noon

May 17
MASA Fifth District Caucus
Huntsville, AL
Four Points Hotel - 1 p.m.

May 21
MASA First District Caucus
Mobile, AL
DePaul Center-Providence Hospital - 6:30 p.m.

May 21-25
29th Annual Pediatrics Symposium, "Practical Pediatrics" and Pediatric Advanced Life Support (PALS)
Destin, FL
Contact: Medical Education Council of Pensacola (850)416-6557

JUNE

June 1-3
Alabama Chapter, American College of Emergency Physicians
Destin, FL
1998 Loss Prevention Seminar - Communicate Your Way to Effective Patient Relationships
Contact: Mutual Assurance, 1-800-282-6242 or Leland Holman, ACEP, (334)265-0068
CME Credit: 2 hours of Category 1

June 8-11
AAFP Annual Scientific Assembly
Panama City, FL
Contact: Holley Midgley (334) 263-6441 1-800-239-6272
CME Credit: TBA

June 9-13
General Surgery Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD
Lloyd Noland Foundation (205)783-5276
CME Credit: 19 hours of Category 1

June 12
Alabama Academy of Family Physicians
Panama City, FL
Communicate Your Way to Effective Patient Relationships
Contact: Mutual Assurance, 1-800-282-6242 or Holley Midgely, 1-800-239-6272
CME Credit: 2 hours of Category 1

June 14
Alabama Society of Internal Medicine 1998
Orange Beach, AL
Loss Prevention Seminar Communicate Your Way to Effective Patient Relationships
Contact: Mutual Assurance, 1-800-282-6242 or Judy Lovelady, ASIM, 1-800-239-6272
CME Credit: 2 hours of Category 1

June 16-20
Adult Infectious Disease Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD
Lloyd Noland Foundation (205) 783-5276
CME Credit: 19 hours of Category 1

June 23-27
Pediatric Infectious Disease Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD
Lloyd Noland Foundation (205) 783-5276
CME Credit: 19 hours of Category 1

June 25-28
Dermatology on the Beach
Destin, FL
Contact: Eric W. Baum, MD
(205) 543-2380
CME Credit: 15 hours of Category 1

June 25-28
1998 MASA Annual Session
Point Clear, AL
Contact: MASA Education Department (334) 263-6441
CME Credit: 14 hours of Category 1

President *(continued from page 2)*

these days as physicians? As an association, as physicians in society, we profess the ideals of caring for patients regardless of circumstances or finances, of advocating for the rights of patients to choose their physician, their rights to understand how their health care is being organized and delivered to them, to understand the many choices we face with them as their physicians. Of course, it is necessary to translate such ideals into action, the action of marketplace and government. And so in government, we are addressing Medicare compliance, home health, the Children's Health Insurance Program, the Tobacco Assessment, Medicaid reforms, liability issues, and the entire array of candidates in this year's elections, most notably the Supreme Court, Governor, Lieutenant Governor, and the legislature. In insurance and health care financing, we are advocating patient protection through marketplace principles of ethical managed care; we are developing methods for evaluating and rating managed care entities; we are monitoring the growth and impact of managed care and keeping you informed; we are advocating for you through the Third Party Task Force.

As an association, we are looking strategically at who we are, why we are here, and where we need to be going. Our outstanding new Executive Director, Cary Kuhlmann, has set a busy pace as we follow a strategic plan that he describes herein. The most important changes we are making for you as our members are those which try to get you reengaged with the work of your Association. For years, we've talked about working more effectively with county medical societies and with specialty societies. Now the rate and depth of change in health care leave us the choice of being authors or victims. Your Board has begun a systematic approach to building our liaison with these groups and to expanding the roles of the Council on Medical Service and Membership Sections (Young Physicians, Medical Students, Residents, and a proposed Governmental Physicians Section).

Finally, as individual physicians, what are we professing? Much of our time is spent in professing technology.

Get this test.
Swallow this pill.
Take this operation.
Follow this diet.
Quit smoking.

Despite the disincentives of time, paperwork, and reimbursement, we aspire to profess mutuality:

How should you and I decide whether you need a diagnosis?
Are the benefits of lowering your cholesterol greater than the risks of this medicine?
How can I help you decide about surgery?
Will this diet help you live longer, or will it just seem longer?
Let's talk about why it's so hard for you to give up cigarettes.
What bothers you - irritates you - confuses you - limits you - scares you?

Where's the virtue to be found here? How do we bring the power of shared experience together with the power of technology? How do I talk to a patient with newly diagnosed cancer - or coronary disease, or arthritis - about his life, as well as his disease? How do I do it under the pressures of medical practice in 1998 - from insurance companies, from

employers, from government, from trial lawyers, maybe even from other physicians - how do I find the time and energy to do it?

Maybe it was obvious to Hippocrates and the ancient Greeks. Maybe the paucity of technology and effective therapy made sharing the experience one of the few things a physician could offer. But is it still important? Patients tell us it is. Even polls say it is. It's important because patients need it. And because they need it, medical ethics and Hippocratic medicine say they deserve no less from us as their physicians. Whether it's harder these days or whether it's always been this hard, I don't profess to know. I do know that nobody can legislate their need or our obligation away. No gatekeeper system can filter it out. No prior authorization can deny it. We just have to do it. Because it's that fundamental, we need to listen closely to what Professor Finley is saying. ★

Executive *(continued from page 3)*

Second, the Board has re-energized the Council on Medical Service to be proactive in MASA's approach to managed care, practice management and specialty society issues. Richard Carson has been moved from Government Affairs to head this area. It appears that the members like what they see with this move as both at-large vacancies to the CMS will be contested elections at the annual session.

Third, the Third Party Grievance Task Force has dropped the "Grievance" part of its name. This is a move to expand the image and purpose of the Task Force so that it can address more than just complaints. The Task Force is projecting a new image to third party payors that MASA wants to address administrative "hassle" factors that add nothing to the value of medical services but, more than likely, may interfere with the physician/patient relationship. Wendell Morgan continues to provide staff leadership to the Task Force.

Fourth, the Board has made a commitment to leadership development by conducting the Leadership Conference which was held January 30-31 (drawing over 120 county, specialty and MASA leaders) and continuing leadership development with additional programs at the June 25-28 annual session at Point Clear. The Leadership Letter was initiated. This is a monthly communication which goes to MASA, county, specialty and Alliance leaders to keep them informed of Board actions and special programs.

Fifth, the Board renewed its commitment to high quality continuing medical education. Through the Education Department's accreditation of hospitals and other entities across Alabama, over 37,000 hours of CME were offered in1997 to physicians and other health professionals. George Oetting retired with Lon on December 31, and, keeping it in the family, Diane Oetting was hired to succeed him. Diane brings much experience in meeting planning with her, not only from the Houston Association of Realtors, but from growing up with MASA CME programs as she accompanied her Dad to many of the programs.

Sixth, the Board came to closure on a strategic plan which began in late 1995 with a survey of member and non-member physicians. After a roundtable discussion among physician leaders and staff, five action

Executive *(continued)*

areas were identified as priorities for MASA. They are:

- Membership
- Grassroots networks for membership and legislative activity
- Improved image through public health projects
- Improved communications
- Improved specialty society alliances

Membership is being addressed by the re-organized Membership Department described above. Grassroots networks are being developed for membership retention and recruitment, and the Governmental Affairs Department, headed by Dickey Whitaker, is building on its already existing key contact and legislative networks. This effort will include working closer with the Alliance. Also, MASA's annual Washington DC trip, begun by Dickey 21 years ago and now coordinated by Mark Jackson, was the best ever, attracting 130 physicians and spouses. This is a major event in building an effective grasssroots network to address federal issues.

MASA is involved already with several public health projects, including the Coalition for a Tobacco Free Alabama, a teen pregnancy project, Stop America's Violence Everywhere (S.A.V.E.) and the Children's Health Insurance Program. Working with the Alliance to identify specific public health care needs in Alabama, MASA will make a decision toward the end of 1998 as to where its resources can have the greatest impact.

Communications are being improved under the direction of Amanda Jones, who succeeds Bill McDonald in this department. Amanda heads the staff's Technology Committee which is responsible for improving the effectiveness of the MASA website (www.masalink.org), broadcast fax and e-mail networks. Amanda is working also to improve the effectiveness of the Alabama MD and MASA Review as well as the development of other communications coming out of this office.

Improving specialty society alliances is the responsibility of the Council on Medical Service and programs and projects are underway already. A major effort is to have several specialty societies meet at the time of MASA's annual meeting to reduce costs and improve involvement in the MASA House of Delegates. Coordination and support of legislative efforts and third party payor relations present other opportunities to combine MASA and specialty society resources.

That's a lot of stuff!! What MASA is doing now presents its leaders, members, spouses and staff with opportunities to make a difference in patient care and in influencing the environment in which that care is provided. But we need to be together in our efforts. I like to think of physicians and their organizations in terms of soldiers in combat. A single soldier can have a limited impact, a platoon of soldiers more and a company of soldiers even more. But as an army, now you're talking about an impact! Think about how strong Alabama physicians could be if they rallied around one organization and concentrated their efforts on an issue. That would be a formidable force. I would like to see MASA as the "flagpole" around which the physicians of Alabama rally.

I look forward to working with you toward that goal. ★

Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800.282.6242/205.877.4400

Ethics *continued from page 7*

giving medical treatment and symbolizes the human body's return to original vigor after shedding the skin of infirmity.

The legends of Asclepius' healing abilities were very powerful in Greek life and were promoted by the Romans. Many cities built temples in his honor. Those at Athens, Cos, Corinth, Argos, and Epidaurus were among the most elaborate, but as the cult of Asclepius grew in the ancient world, hundreds of temples were built from Asia Minor to the western Mediterranean. These priest-physicians placed tablets with names of patients healed and their diseases at the entrances. Sacrifices of animals, bulls, lambs, and pigs were made at the altars. These sacrifices were made to Asclepius and Hygieia at least twice a year.[17]

Hippocrates, known as the "father of medicine", was born on the Island of Cos in 460 B.C. He was a Asclepiad or "son of Asclepius" and his early studies were in the Temple of Asclepius. It is said that Hippocrates represented the 17th in line of descendants from Asclepius.[18] Cos, an island close to Asia Minor, was settled by colonists from Epidaurus who built the temple that became a health resort and the first school of scientific medicine.[19] Hippocrates was known for classifying diseases and recording his experiences in treating specific diseases. The Hippocrates Collection, the oldest documents on the practice of medicine, brought together at the medical school in Alexandria in 300 B.C., contained the oath and other writings on various subjects.[20] Hippocrates lived in the time of Socrates, Plato, Herodotus, Sophocles, and others and during a remarkable period in the history of man.[21] He stressed prognosis more than diagnosis and considered every disease to have its own nature and to arise from external causes.[22] Hippocrates began the liberation of medicine from religion and philosophy and based medicine on experience, not empiricism.[23]

Hippocrates was known to have had a bold practice, however, he provided the profession with the general rule that physicians in the regulation of treatment should do good or at least do no harm.[24] He is noted to have believed in conciseness and precision in his writings.[25] An example of his contributions is the recognition that his treatment of congenital club feet is appropriate even today.[24]

In the pre-Christian era a guild-like organization such as the Asclepiads and its recognition by rulers gave medicine status. Asclepian temples began to decline in influence after the spread of Christianity. By 4 A.D. the Emperor Constantine began the wholesale destruction of the temples. However, the symbol, Staff of Asclepius, became increasingly important through the centuries. Now some confusion has evolved about whether the Staff of Asclepius or the Staff of Hermes is the symbol of medicine. The Staff of Hermes (Mercury), or caduceus (2-snakes intertwined) had origins as far back as early Egyptian history when snakes were worshipped.[26] Staffs in Greek mythology

represented the vitality of the earth. Hermes thrust his staff between two snakes which stopped fighting and wound themselves about the staff. Therefore, this symbol was to become a representative of the settlement of quarrels (and even as a banner used in surrendering, much as a white cloth is today). The wings pictured on the symbol illustrate the speed of Hermes (Mercury).[27] Homer described Hermes as a messenger and as one who runs errands for the greater gods, especially Zeus. The Hermes staff has been used as a symbol for medicine by some since the Renaissance. The caduceus was first used as a symbol of medicine in the 16th century and the reason is not known.[28] In 1792, a Boston dentist, Josiah Flagg, Jr., used the caduceus in an advertisement.[29] The Medical Department of the U.S. Army adopted a single serpent emblem in 1818. At the turn of the 20th century, the 2-snake caduceus became the emblem of the U.S. Army Medical Corps. However, the Staff of Asclepius, not the caduceus, has been considered the authentic symbol of medicine and the American Medical Association, New England Journal of Medicine and many other professional and health organizations have adopted it as such.

It may be that Judeo-Christian teachings have been the only or the major contributor to the moral and ethical tapestry of modern western medicine. The Ten Commandments were provided Moses at about the same time, 14 centuries B.C., as were Asclepius' contributions. Even prior to this time, the snake had been worshipped in Egypt. The snake had particular recognition during the Exodus. The Lord sent fiery serpents among the Israelites to bite and kill them. However, if those who were bitten beheld the brass serpent on the pole erected by Moses they lived (Numbers 12:6-9). This association of health with the snake as an emblem may not have been known in Greek legends since the Jewish people were not traders.

The teachings of Christ with regard to interpersonal relationships undoubtedly provided the basis for moral and ethical values. The scripture in Matthew (7:12) indicates that all things whatsoever ye would that men should do to you, do ye even so to them. Throughout the scriptures and particularly the gospels are guidelines for personal relationships. None are quite so specific as is recorded in the 12th and 13th chapters of Romans.

The writings of Galen dated from about two centuries after the birth of Christ were the strongest influence on medicine from then until the 19th century. Galen (129 - 210 A.D.), a follower of Asclepius, was healed at one of the temples and was assisted by Asclepius in his dreams.[30] Galen accepted a divine design of nature but rejected miracles.

In the early 19th century, the English physician, Thomas Percival, published a code of conduct for physicians at the encouragement of his colleagues. His treatise has been judged recently as the most influential document in Anglo-American medical ethics.[31] Percival's character and values prompted this request and his treatise was revised several times

Ethics *(continued)*

over a few years but finally published in 1803 shortly before his death.

The code of ethics attempted by the American Medical Association in the 1840s used some of Percival's code. Other American medical societies used Percival's Code in guiding their professional actions.[32] Several revisions of the AMA Code through the years after much debate each time, resulted in the recent publication and distribution of the 1997 revision.[33] It identifies seven principles of medical ethics. A physician should provide competent medical service, deal honestly with patients and colleagues; respect the law; respect rights of patients, colleagues, and other health professionals; continue to study, apply, and advance scientific knowledge; be free to choose those who are served except in emergencies; and recognize responsibility to participate in activities to improve the community. The spirit of Percival's ethics still persists in the AMA code according to Pelligrino.[32] There is an increasing interest in medical ethics within the profession and without. Failure to manage research breakthroughs, economic pressures, health plans, genetic manipulation, societal goals, life support mechanisms, together with maintaining the patient-physician relationships may contribute to an uneasiness about the direction of health care measures.

There began gradual improvement of the image of medicine at the end of the last century when medical training was being influenced by new scientific contributions. The main ethical questions for medicine at the beginnings of the 20th century were confidentiality, specialization, consultation, referral, and public health responsibility. From the middle of the 19th century the American Medical Association began considering the significance of a pledge as a reflection of the values held by the medical professions.[34] There is much variation among medical schools in the use of an oath for the newly graduated physicians. If an oath is used it is often a form of the Hippocratic Oath. In addition to the traditional ethics questions there now seems to be an additional challenge. This challenge is centered around a feeling that the public and the profession itself envision a threat of commercial restraints on the selection of health professionals, and limitations on patients' access to care. These social pressures may lead to further examination of traditional values held by physicians.

It is our continuing responsibility to examine new technologies and to fit them in a moral and ethical manner on the traditional framework for what is right. We have a time-honored emblem and oath on which to place new interpretations. These, of course, should be above reproach. The oath tells the public what the traditions have been and will be for physicians and what ethics physicians have assumed. May the symbols and the commitments of each of us always honor our profession and be a beacon to society to provide health care and comfort. The physician is taught to give of his time, compassion and care; and to provide acceptable treatment, counsel, and hope to

patients regardless of social status.

Delivery of quality health care is the primary goal and the various economic pressures and organizations for delivery of care, now and in the future, should not alter the goals of physicians. Physicians cannot tolerate anything short of delivering the latest proven health care measures backed up by research. The availability of much knowledge from medical research places new responsibilities of staying informed about new treatments and ethical pressure to apply the latest techniques and treatments. Fortunately, new information access technology will aid health professionals in remaining proficient in new procedures and techniques. Yes, we do have a code, and it is clear that the new generation of physicians will carry on high ethical principles, taught by example and tradition by the previous generation of physicians. The high principles will be obvious as the new technologies are incorporated into health care. Health care personnel will want input from the public in the consideration of the ethics of new breakthroughs. ★

References

1. Carmichael, AG and Ratzan, RM (editors). 1991. Medicine, A Treasury of Art and Literature. Harkavy Publishing Services, New York. p. 35-36.

2. Adams, F (Translator). 1849. The Genuine Works of Hippocrates. Sydenham Society, London, Classics of Medicine Library, Birmingham, 1985. p. 9.

3. Bailey, JE. 1996. Asklepios: Ancient Hero of Medical Caring. Annals of Internal Medicine. 124: 257-263.

4. Adams, F: op. cit. p.5.

5. Greek National Tourist Organization. 1992. Greece Kos. A Travel Brochure. p.2.

6. Carmichael, Ratzan: op. Cit., p. 49-51.

7. Adams: op. cit., p. 5.

8. Rouse, WHD. (Translator). Homer: The Iliad. Penguin, New York. p. 51.

9. Adams: op. cit., p. 5.

10. Edelstein, E and Edelstein, L. 1945. Asclepius, A Collection and Interpretation of the Testimonies. Vol. 1, Johns Hopkins Press, Baltimore. p. 30.

11. Shampo, MA and Kyle, RA. 1992. Medical Mythology: Chiron the Centaur. Mayo Clinical Proceedings. 67: 158.

12. Shampo, MA and Kyle, RA. 1993. Medical Mythology: Hygeia. Mayo Clinical Proceedings. 68:441.

13. Edelstein and Edelstein: Op. Cit., p. 10.

14. Ibid, p. 345.

15. Ibid, p. 362.

16. Frett, PT. 1994. Medicine's Identity Crisis Revealed: The Asclepius vs. the Caduceus. Minnesota Medicine. 77:48-50.

17. Edelstein and Edelstein: Op. Cit., p. 304.of the Testimonies. Vol. 1, p. 309.

18. Ibid, p. 102.

19. Encyclopedia Britannica. 1968. William Benton, Publisher. University of Chicago, Vol. 6, p. 562.

20. Adams: op. cit., p. 1.

21. Ibid, p. 10.

22. Encyclopedia Britannica. 1968. Vol. 15, p. 94.

23. Adams: op. Cit., p. 18.

24. Ibid, p. 20.

25. Ibid, p. 21.

26. Geelhoed, GW. 1988. The Caduceus as a Medical Emblem: Heritage or Heresy? Southern Medical Journal. 81: 1155-1161.

27. Shampo, MA and Kyle, RA. 1992. Medical Mythology: Hermes (Mercury). Mayo Clinical Proceedings. 67: 800.

28. Wilson, R. Jr. 1922. The Caduceus and its Symbolism. Annals of Medical History 4: 301-304.

29. Weinberger, BW. 1944. An Early Record of the Use of the Caduceus in America. Bulletin of the History of Medicine. 16: 410-413.

30. Bailey: op. Cit., p.

31. Pelligrino, ED. 1985. Thomas Percival's Ethics: The Ethics Beneath the Etiquette. In Introduction to: Percival, T. 1803. Medial Ethics; or, A Code of Institutes and Precepts, adapted to the Professional Conduct of Physicians and Surgeons. Manchester. Classics of Medicine Library, Birmingham, p. 1.

32. Ibid, p. 10.

33. Council on Ethical and Judicial Affairs. 1997. Code of Medical Ethics. American Medical Association. Chicago. p. XIV.

34. Smith, DC. 1996. The Hippocratic Oath and Modern Medicine. Journal of the History of Medicine 51: 484-500.

Visit MASA's website at

masalink.org

Medicare *(continued from page 13)*

Medicare taxes will consume 28% of each working person's paycheck by the year 2030, and that is before considering any local or state taxes. The point is American people are still in a state of denial on this issue. We have a brief respite with the Balanced Budget Act and it is coming to an end quickly. The fact is that an average American family of four today pays approximately more than one third of its income in taxes, including federal, state and local taxes. Actually, now it's closer to 40%.

The Medicare trustees have been very, very blunt and very kind in telling us exactly what it will mean in terms of the hundreds of billions of dollars in extra taxes that we are going to have to pay unless we get this thing straight. Medicare is growing faster than the economy. It is growing faster than the resources that are available to pay for the program, even with the Balanced Budget Act of 1997. According to the Congressional Budget Office in 1997 we spent $209 billion for Medicare benefits or approximately $5,500 per beneficiary. In 2015, according to CBO, we will see Medicare enrollment jump from roughly 38 to 53 million people. That is roughly 50% more beneficiaries than we have today. According to CBO, Medicare spending will increase by a factor of five, to 1.1 trillion dollars and that comes out to $20,000 per beneficiary. And basically that means the tax burden on the American people is going to be absolutely extraordinary. Medicare is a payroll tax. It is split between employers and employees. Grown-ups know that companies don't pay taxes. They are passed on to workers in lower compensation or lost wages or even job loss.

There's another odd aspect about this entire financing arrangement. Medicare as a system is now an income transfer system from lower income, often poor working people, to often well off, well-heeled retirees — some of whom have six figure incomes. So you have a strange kind of Marxism in reverse. It's an odd kind of thing, from each according to his labor and to each according to the size of his trust fund.

But the real situation could even be worse with regard to Medicare projections and that is that government estimates on the cost of Medicare have almost always been wrong. They have never gotten it right. One thing is infallibly true, government actuaries have never overestimated the cost of Medicare. Never.

Having said all this, it's not clear that official Washington Republicans or Democrats will do the right thing on Medicare. Republicans are capable of doing some very, very strange things. My colleagues at the Heritage Foundation are studiously, nonpartisan, aggressively conservative, but we expect even less of the Democrats and we get it.

On the other hand, partisan rhetoric aside, the makings of consensus are there. Regardless about what anybody thinks we ought to actually do with Medicare, both the White House and Congress know that it is mathematically impossible to keep the fed-

Medicare *(continued)*

eral budget in balance unless you control Medicare spending.

Right now approximately 50 percent of all federal spending is entitlements. It's not discretionary funding, it's entitlements. Approximately two-thirds of all federal spending are on the big entitlement programs — Medicare, Medicaid, Social Security, retirement programs and payment of interest on the national debt. In other words, we can cut all the waste, fraud and abuse we want, it's not going to have any real affect. By the way, foreign aid is only about 2 percent federal spending. So if you decide that Medicare is not to be changed, we're going to keep things going as they are, that means you must argue logically for multiple future tax increases on working families or alternatively cuts in benefits for the elderly. Or, we might as well bust the budget and borrow. That means that you must logically be committed to higher and higher deficits and that means that you're going to be paying higher interest on the national debt. It also means you're going to guarantee yourself a lower standard of living.

So there is a cost of doing things and there's a cost of not doing things and if Congress fails to maintain the balanced budget that is going to have an effect on everybody in this room.

The second point to remember, is that the projected level of Medicare spending is right now equal to about 13 percent of all federal spending and growing. They know that so the question is what do we do?

To say that we cannot continue to run Medicare in the current fashion is a dull and uninspiring proposition. Of course we can't. We're really coming to the end of business as usual on this. Time is a relentless opponent. A new politics based on intergenerational conflict is coming. Think of it. More bitter than anything that we have ever seen before as one hopeless, debt ridden generation fights the other over an ever diminishing spoils of a financially bankrupt government health and retirement system. In a country whose productive capacities are being sapped by oppressive taxation, it's a sobering thought. Even twenty-something's will perhaps get serious and turn off Pearl Jam, turn around their baseball caps and start asking the dudes and dudettes in Congress some totally awesome questions about their future. Could happen.

You've got one year before the (Medicare) commission comes up with some recommendations. There's a lot that can happen. A year is a very long time. It's also a very short time in one sense. It's a long time in politics - a very short time in the overall scheme of things.

Dr. Curry asked me, " Well, what could doctors do?"

Let me give you a very concrete suggestion. State and county medical societies can play a decisive role in this debate by getting together directly with the congressman, Republican, Democrat — it doesn't make any difference, and have town hall meetings. You sponsor them, with the congressman as host, and invite both sides on this issue to debate. I'm talking about the AARP surely and some of the

representatives of the younger organizations. Invite representatives of the Clinton administration, they'll come. Invite the administration's critics and have it out.

Medical societies can do that and it's not threatening to a congressman. He doesn't have to take an exact position. But you can lead the debate. Let me tell you the questions that I think you ought to press for.

First, who is going to make the key decisions in the system? The new system. Who is going to make the key decisions about what kind of plan Americans are going to have? What kind of benefits they will have? What kind of treatments they will be able to have? What kind of prescription drugs or catastrophic coverage you will have? Who your doctor will be? What will you pay in co-payments, or deductibles or premiums and how will you pay for it? Who will choose your doctor? Who will determine your access to specialized medical care? Who will decide what treatments or medical procedures are going to be available to you? These are key questions. They are not metaphysical abstractions. These are real serious questions.

Do you want Congress to make these decisions? Do you want an unelected board appointed by the president to make these decisions? Do you want the Health Care Financing Administration to make these decisions? Do you want state sponsored regional alliances or employer managed care corporate organizations or networks to make these decisions? Or should individuals and families in consultations with the doctors make these key decisions?

These questions have got to be answered. Again, they are not rhetorical. These are real questions. As you all know, the reason why there is such anger and frustration about managed care is that people thought that they were going to get treated for something and it's not there. And they get so frustrated what do they do? They write the experts on health care — the state legislature. They know all about these medical treatments and procedures, don't they?

The second set of questions really involves the financing. And the questions are: Who at the end of the day controls the dollars in the system? Who decides how much doctors are to be paid and how they are to be paid? Remember, he who controls the flow of dollars controls the system. The person who controls the system drives the system, gives the system it's character, it's shape. Remember the golden rule, right? He who has the gold makes the rules. It's the oldest rule in the world and it will outlast every human contrivance to make it appear other-wise.

Those are key elements. Who controls the dollars and who makes the key decisions in the system. And frankly, there are a lot of candidates, but for the American people, there is only one. When they make decisions about their health and they make decisions about their options, they want to talk to physicians. They don't want to talk to the Health Care Financing Administration or Senator Kennedy. They don't want to talk to the Heritage Foundation. They want to talk to you. That's the key element

Medicare *(continued)*

here.

During the past couple of years, members of Congress, including Sen. Breaux, asked my colleagues at the Heritage Foundation to present to them a model for reforming Medicare and we have done so. I think what we have done is to propose something that would look sharply different from the Medicare system we have today. Our preferred option is to change Medicare into something that is entirely new, but not one that is untested and not a model that does not have a long track record.

We proposed to Congress that it create a Medicare system that looks very much like the Federal Employee Health Benefits Program. The program is unique. It is a unique consumer driven health care system that is based on two key free market principles: consumer choice and competition. The 38-year-old FEHP, as it is called, has nationwide about 600 health care options, ranging from large traditional fee-for-service plans to geographically based HMOs, all competing directly for the dollars of federal workers,

Before I get into the specifics, I want you to ask yourself another question. It is a political question. Do you think that members of the House and Senate would have designed a second rate program for providing a broad range of private health insurance plans for themselves? I think that's the question that should be asked and I think it's a question that should be asked to the elderly.

The Federal Employee Health Benefits Program is based on the two principles of consumer choice and competition. Where people get to pick and choose the plans that they want and the benefits that they want at the prices that they wish to pay, with no standardization of benefits, no standardization of deductibles, no standardization of premiums, no rbrvs, drg's, etc. The fact is that from the standpoint of cost control it has long out-performed private sector insurance, and, needless to say, Medicare's cost performance is a joke compared to this. One year, I think it was 1995, the Federal Employee Health Benefits Program actually had a decrease in premiums of 3.4 percent and something like 40 percent of all enrollees actually paid much less, including retirees, than they were paying the year before in actual dollars.

The federal system is actually performing better than its own numbers show. The benefits in that system over the past 15 years have actually gotten progressively richer and more varied. Unlike the private sector where you see they are cutting back on benefits. Another and most significant point is that unlike many large corporate private sector plans the FEHP covers retirees. In fact, 40 percent of all subscribers in this system are retirees. Now yes, many of them do have Medicare, but the actuaries will also tell you that even with Medicare, retirees in the FEHP are more expensive than active workers. And yet another fact is, the President announced it in his state of the union, the active federal work force is declining. All the new people who

are in the FEHP are federal retirees and the federal work force itself is older than the general population. This is not an ideal insurance pool. Yet in terms of cost control, it does one hell of a job. And most of their success is directly attributable to two things. The principle of consumer choice, where people can pick and choose the plans they want, and competition.

Competition among insurance companies is something you probably have never actually really seen. What you've seen is where corporate benefits manager get together with insurance companies and sign a contract that is going to affect a whole bunch of other people. But the idea of insurance companies competing directly for the consumers dollars, where the consumer can fire the health insurance company just like they can fire the life insurance companies, or auto insurance companies or home owners insurance companies or any other type of insurance companies, that's something that Americans have not really seen very much of. They saw it here for the past 38 years. And let me tell you, I can assure you that the FEHP is a good model for this reason — the people who are in it, love it. And if you attempted to take it away or compromise it in any way, or include it under, for example Hillary Clinton's idea of health care reform, they will go bananas. They will threaten you with bodily harm.

During the debate on the Clinton plan there was a problem. It was an embarrassment. The federal union had a press conference and they had a big announcement to make which was that "we are for national health reform and we are for the Clinton plan for everybody in America. We think that everybody ought to have it except for us. Thank you very much." And they tried to get themselves out from under it. In fact, they cut a deal with the White House where they did. What the White House did is basically create this remarkable provision in the Clinton plan which said that America will be kind a of experiment to see how it goes and if it works out all right then the federal employees will come under it. I'm exaggerating a little bit on the details, but that's basically what the provision was.

Well, what do we do in terms of reform? One is that nobody in Medicare today should be forced to do anything they don't want to do. And if you are in Medicare, and you like the Medicare system — if you practice in Medicare and you like the Medicare system — you love HCFA — you think that the technical advisory committee just does a great job, if you are a patient and you are happy with it — you realize that you have to purchase catastrophic coverage independently with the Medigap coverage — you have to buy prescription drugs extra and all that, but you are happy with it, then you should be able to keep it. Nobody should bother you at all.

If, however, somebody wants to change, and they say "Look, why can't I just keep my company based plan?" Why not? Or a plan sponsored by a union that they belong to. Well why not just let them do so? How would you do that? This could be done by giving any retiree who wants

it a defined contribution. The federal government contributes a certain amount toward the cost of a health care plan. In principle this is exactly what the federal government does today for congressional employees, members of Congress, House and Senate, federal workers and retirees. There is a variety of ways to do it. You don't have to hand them a voucher. You don't have to hand them a certificate and worry about whether in fact they'll spend it on, I don't know, a cruise or something like that. You don't have to do that.

Probably the easiest thing to do is for Congress to simply abolish the trust funds and replace the trust funds with a Medicare account, and have an electronic transfer from the treasury to a plan of the retirees choice.

This is what the government does today for federal workers and federal retirees. In any case, the key thing is that the patient will control the dollars. The patient will control the flow of money. If the retiree buys a plan that costs less than the government's contribution, then they would be able to pocket the savings. If the retiree wants to purchase more coverage than is found in the basic benefits package they can do so, just like federal workers and retirees do today. But by giving retirees direct control of dollars they can use them for the existing Medicare plan or any other plan that they want. And you're talking about a variety of potential options. I mentioned union plans, association plans, independent organizations, employer or corporate plans, or medical savings accounts. If somebody wants to take that money and open up a medical savings account and pay directly for routine medical expenses, I mean that makes imminent sense, it also gives people absolute freedom and it gives the doctors a direct relationship with the patient.

The use of the contribution should be neutral. In other words, the government shouldn't decide that you can have the contribution for only one type of plan. A managed care plan or an HMO or a PPO or whatever it is, let people decide what they want. Conceivably some of them might make good decisions without HCFA's help.

Congress has got to fix the amount of the defined contribution. Certainly there has got to be a formula for this. In any case the amount and the formula for the contribution, should be explicit. Taxpayers should know exactly, clearly what they are going to pay and the beneficiary should know exactly what they are going to get. The per capita spending for Medicare right now is set at $5,500 annually. That's a very solid base to work from. The government contribution can be adjusted by age, by sex, by geography. You don't have to adjust it by health status. Age, of course, is the most important factor in adjusting a contribution. And certainly we should means test these things, shouldn't we? I mean with a view toward channeling funding or assistance to lower income folks and less to high income people. We should reverse the absurd social policy that we have today where we have income transfers for lower income people to

upper income people.

And establish consumer protection. Much like OPM does for federal workers. Establish protection for the people in the system. Make sure that the plan meets basic fiscal solvency requirements. This shouldn't be hard. I think any plan competing in a new system should at least be in better financial condition than the current Medicare system. I think if we use that as the base we'll be in pretty good shape. A plan should have to clarify its services and its costs in plain English, just like federal plans are required to do today. We should establish a core benefits requirement. Competing plans should have to provide catastrophic coverage. Nobody should be able to compete without catastrophic coverage, as you all know Medicare does not provide any catastrophic coverage.

Allow the plans to compete on price and quality. You would have discounts for persons who enroll in preventive health care plans, health promotion programs or engage in other activities that are designed to promote their healthful life styles. You can certainly operate a real premium structure that reflects that.

Finally, restrain the bureaucracy. One of the things that I am concerned about is that Congress may do the right thing in legislation, but not do the right thing with HCFA. Let me be very clear. You can put together a terrific legislative package, but if the regulatory authority of the Health Care Financing Administration is not restrained you can undermine what you are trying to accomplish. HCFA should be grounded. You have to take the car keys away from HCFA. Whatever you do, you can't let HCFA out in the dark.

So one of the things that we are suggesting is that Congress should impose very clear restraints on HCFA. Let me be specific. HCFA should run traditional Medicare if they want it. That should be their job. They should be forbidden, under pain of a Kenneth Starr investigation, from imposing or administering any system of price control, fee schedules, caps or premium, spending restraints or any kind of restrictions on private health insurance plans getting a defined contribution. HCFA should also have no authority to organize health plans in any region of the country, setting up cartels or oligopolies or government sponsored purchasing cooperatives. The last thing we need in insurance is government promotion of consolidation of insurance companies.

HCFA should have no authority to impose any government defined standardized benefits package beyond the certification of core categories of benefits and catastrophic coverage and HCFA should have no authority to make any determination regarding the treatment for medical procedures that any private plan offers. You have to restrain them.

The basic idea I think has been floated around in one form or another by a variety of leaders and institutions. Your American Medical Association supports this idea. The Progressive Policy Institute, which is a moderate, Democratic think tank very strongly supports it, many others do. Details differ but it has been

embraced. In fact, it is becoming embraced by a broader variety of people than we would have ever imagined. Liberal democrats have endorsed this idea as have conservative Republicans.

The key thing is a defined contribution where the patients can take their money to the doctors and the plans of their choice. In every form, in every debate, in every discussion on Medicare reform keep the focus on the key issue. Doctors are not going to be empowered unless their patients are empowered. You want to have a relationship which makes sense and you will not have a relationship that makes sense outside of defined contribution. If we reform Medicare a year from now and we end up with the same kind of defined benefit system, everything that you are complaining about — fraud and abuse and HCFA and the paper work — you are going to still have it.

The second thing I would recommend to you is to focus on the Congress. Get to know your congressman personally. I know that you have no time. I know that there is no group in the country that is busier than you. I know what your schedules are like, but here is the key element. If a member of Congress comes back to the district you and a few of your friends get together with him. They are accessible. Just make it a habit every couple of months and tell them about the things that bother you.

Most members of Congress hate this issue. A lot of them don't understand Medicare or they don't understand Medicare policy. They are frustrated about it, they are afraid of it because of the politics of it. They don't like it, but what they do not understand and will never understand unless you personally tell them plainly, is how their policies affect your ability to do your job. If doctors did this in every Congressional district in the country it would have a profound impact on the way Medicare does business.

Finally, and this is a critical point, recognize your leadership role. I said earlier, take the lead in this debate. You can do it. Take the lead as a professional. No group is potentially more influential in shaping the course of this debate than members of the medical profession.

In closing, I just want to make one final recommendation. Never tolerate, either individually or as a profession, a professional insult. Never allow anyone, especially a health care policy analyst, to call you a provider. You are not a provider. They may not intend it as an insult, it is an insult.

You are a doctor. You have a great responsibility to the American people because you have to protect your relationship with them. With you this is not merely good public policy, it is a moral imperative. Remember that you're heirs to the highest ethical tradition of any profession. You belong to a special community rooted in the prescriptions of Hippocrates and sanctified by none other than St. Luke. ★

Medical Association of the State of Alabama

Point Clear, AL

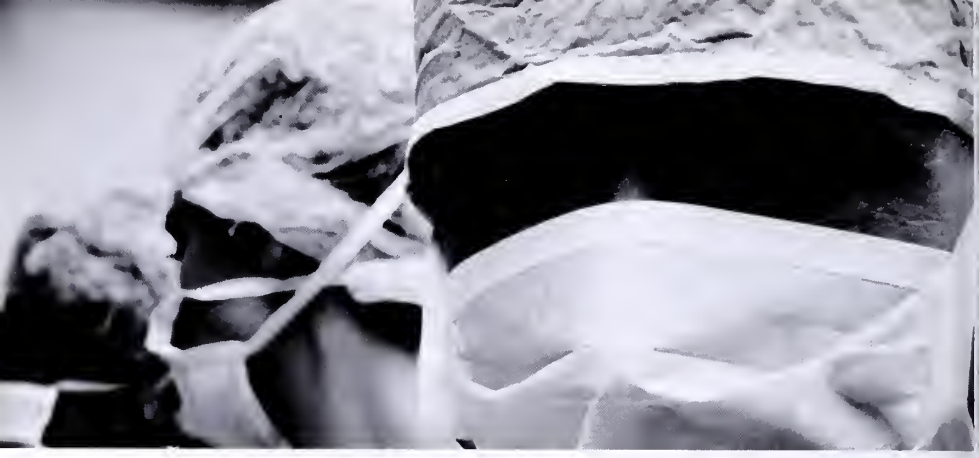
June 25 - 28, 1998

Register Today!
1-800-239-6272

MASA REVIEW

Incorporating **Alabama Medicine,**
The Journal of the Medical Association of the State of Alabama

The Disruptive Physician



Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800.282.6242 / 205.877.440

MASA REVIEW

Incorporating **Alabama Medicine**, *The Journal of the Medical Association of the State of Alabama*

Vol. 2 No. 2 Summer/Fall 1998

USPS 284720 ISSN 0738-4947

Editor William A. Curry, M.D.

Managing Editor Amanda Jones

Book Review Editor David W. Hodo, M.D.

OFFICE OF PUBLICATION: PO Box 1900, Montgomery, Alabama 36102-1900. Subscription Prices: member, $15; non-member $30 per year. Periodicals postage paid at Montgomery, Alabama and at additional offices. Published quarterly by the Medical Association of the State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36102.

POSTMASTER: Send address changes to MASA REVIEW, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for the Medical Association of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1998 by the Medical Association of the State of Alabama.

IN THIS ISSUE

8

The Disruptive Physician

Gerald L. Summer, M.D.
Charles V. Ford, M.D.
William M. Lightfoot, M.D.

18

Confrontation Credits: One Key to Motivation

Peter Land

20

Volunteer Opportunities

Arthur Stamler, M.D.

DEPARTMENTS

President's Message	2
Executive Director	3
Outgoing President	4
Alliance	5
MASA Services	25
Technology Talk	26
Calendar of Events	30
Malpractice Column	32
Practice Management	34
Book Review	38
Author's Instructions	40

Inaugural Address

This speech was delivered at MASA's Annual Convention in June.

Thank you, Mr. President, Mr. Chairman, honorees, distinguished guests, members of the board, delegates and counselors, ladies and gentlemen.

What a wonderful occasion! First, let me say how much MASA appreciates you 50-year members. The 28 of you represent 1,400 years of service to the patients of Alabama. Many of your years of practice were in the good old days...before third party and government intervention into health eare. Back in the days when the doctor-patient relationship was just that... a sacred trust without outside interference from those who would tell you how, when, where, and for how long you should treat the patient. Back in the days when the physician-patient relationship was not considered a potential criminal activity by the interlopers from HCFA, OIG, FBI. Back in the days when payment for care might have been produce from the garden or farm. Back in the days when two of the greatest technological advances in the history of medicine, antibiotics and immunizations were ushered in. Yes, those were the good old days, but these days, though treacherous, can be good, too.

I am also thrilled to be joined here by many MASA past presidents, two of whom I would like to single out...Dr. Bill Curry and Dr. Bill Lazenby. Dr. Curry has been the ideal president: the consummate physician. He understands the issues, he articulates them eloquently, and he has lead with the wisdom and integrity that is essential to our organization. Dr. Lazenby - several years ago I was content, just as most physicians, to see my patients and practice medicine from day to day. Bill told me there was more to it than that...that if doctors didn't get involved in county, state and national affairs, we would be practicing medicine like the feds told us to, like the insurance companies told us to, like other third parties told us to, and that our patients would suffer as a result. He was right.

He encouraged me to run for third district counselor, nominated me for his vice-president, and encouraged me to run for the MASA board and president-elect. He has been a worthy mentor. Thank you, Dr. Lazenby.

Continued on page 41

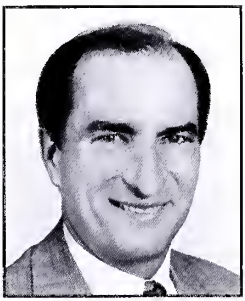
—Joel C. Pittard, M.D.

Thanks for a Great Annual Session

Thanks to everyone who made my first annual session with MASA such a success.

First, thanks to all members, delegates and counselors who took advantage of the excellent education sessions and who participated in the business session on Saturday morning. The education sessions were well attended and provided valuable information which could be applied by members in their practices when they returned home. In the business session, several resolutions were passed which will change fundamentally MASA's organizational structure. These structural changes will allow for more regular turnover of leadership positions in MASA as well as encourage young physicians to become involved earlier in their medical careers. Also, a government employee category of membership was created to encourage the involvement of physicians in a number of practice settings—state universities, state and local health departments, the Veterans Administration and the military. Action by the College and House also committed MASA to an active role in the debate of health system and Medicare reform. (Already, new MASA president, Joel Pittard, MD, has made a presentation to the Huntsville Rotary Club and the message was well received.)

Second, I want to thank those members who ran for elective office. Not only was there competition for president-elect, but also a district Censor seat, an AMA Alternate Delegate place, and positions on the Council on Medical Service and Council on Medical Education. To me, this is a sign of a healthy organization where its members are contesting for leadership positions.



Third, thanks to the rest of the MASA staff who planned, coordinated and executed the numerous activities. This was a new format for the annual session and there was apprehension on making sure that many of the traditional activities of the annual session were conducted in a manner which continued the rich heritage of this association. Tradition was balanced with programming which emphasized the future of medical practice and the challenges physician organizations face. For those of you not in attendance, please see William Curry's retiring president's remarks in

Continued on page 44

—Cary Kuhlmann, Executive Director

REMARKS AS OUTGOING PRESIDENT

The Struggle at the Center

God be in my head,
And in my understanding;

God be in mine eyes,
And in my looking;

God be in my mouth,
And in my speaking;

God be in my heart,
And in my thinking;

God be at my end,
And in my departing.

Sarum Primer, 1558

"As for me, my bed is made. I am done with great things and big things, great organizations and big successes. And I am for those tiny, invisible, molecular forees which work from individual to individual, creeping in through the crannies of the world like so many soft rootlets, or like the capillary oozing of water, but which, if you give them time, will rend the hardest monuments of man's pride."

William James

REMARKS AS OUTGOING PRESIDENT

Fourteen months ago in Birmingham, at the time I was installed as the one hundred thirty-second President of MASA, I described "what I believe to be the values that historically underlie…any actions we take" as an association. I discussed the gifts that we have received and the lonesomeness that we face as individual physicians and as an association.

Like many of your presidents before, I was full of hope and determination, somehow trusting that these great principles would keep us all - leaders, members, and staff - anchored to what was true, resulting in decisions that were wise and timely. I even had a partial suspension of disbelief in thinking that my full time work, family, and personal needs could all be satisfied at the same time we undertook implementation of our strategic plan - a strategic plan that included the most significant restructuring of staff in years, revitalization of grassroot membership involvement, reorganization of Board terms and activities, and greater involvement of the association in issues of public health policy and public education. There were carry-over issues such as patient protection, and there was the likelihood of unexpected public controversy. And, of course, we were headed toward an election year.

Well, it didn't work out very neatly. While I have enjoyed immensely the experience of being your president, I found that those guiding principles do not command automatic outcomes, because, as we all know, in the heat of the moment, it's easy to overlook the big picture. Add to that the messy detail that we are forced to deal with other fallible human beings who also are very busy and very distracted. The only guarantee is that it will be a struggle.

In what I said last year, I actually find a statement that anticipates the struggle created when great principles confront ambiguous situations. Here it is: "…we share a profession that by its nature spends itself in life's toughest struggles. We don't know what the results will be. As Stonewall Jackson said, 'The battle is ours; the outcome is the Lord's.' We do know that it is in the struggle that we find significance; it is in the struggle that we find the relationships with patients and with our colleagues that are what really matter." Well, the year has been a struggle, as I should have expected. It has been filled with great relationships with you, with members of the Board, and

Continued on page 45

—William A. Curry, M.D., F.A.C.P.

Installation Address

This speech was presented at the Alliance Annual Meeting earlier this year.

I am proud to represent the Alliance to the Medical Association of the State of Alabama as your President.

You are the most intelligent, educated, and enthusiastic volunteer force in our state. The Alliance is made up of almost 2,000 men and women who are physician spouses working together for 75 years to enhance community health and improve the quality of life for Alabama's citizens.

Our organization was begun on April the 29th, 1923, in Mobile, Alabama. We were known as the Woman's Auxiliary to the Medical Association of the State of Alabama. Our main objectives were to support the Medical Society, promote public health issues and entertain our members. Those were the "good old days." As we approach the 21st century we have thrown away our hats and gloves, rolled up our sleeves, celebrated, rededicated and even changed our name from Auxiliary to Alliance.

Medicine, like the Alliance, has also changed. Today, we stand at a unique crossroads. We see our medical community being torn apart as never before in history. Issues such as organized medicine, lowered reimbursement plans and malpractice suits are causing us to choose sides against one another. We share the frustrations with our spouses as they struggle with the fear of being sued, the burden of additional paperwork and even the threat of acquiring HIV. Precious family time is put on hold because of the endless demands of modern medicine

Today, lawmakers and insurance companies decide the medical treatment for our spouses' patients. Does 11 years of training plus 12 years of practice not qualify my husband to determine how long his patients can stay in the hospital and what diagnostic tests are needed? We also have empathy for their patients as they struggle upstream against the changes in our medical system and insurance policies. These are difficult times for all.

We are physician spouses. We can make a difference, but only if we are willing to make the commitment to set goals and plan strategies which will produce results. Our only limitation is our expectation for this next year. Face to face we will address the issues of medical families and patients.

Do we have the courage to develop plans that will change the

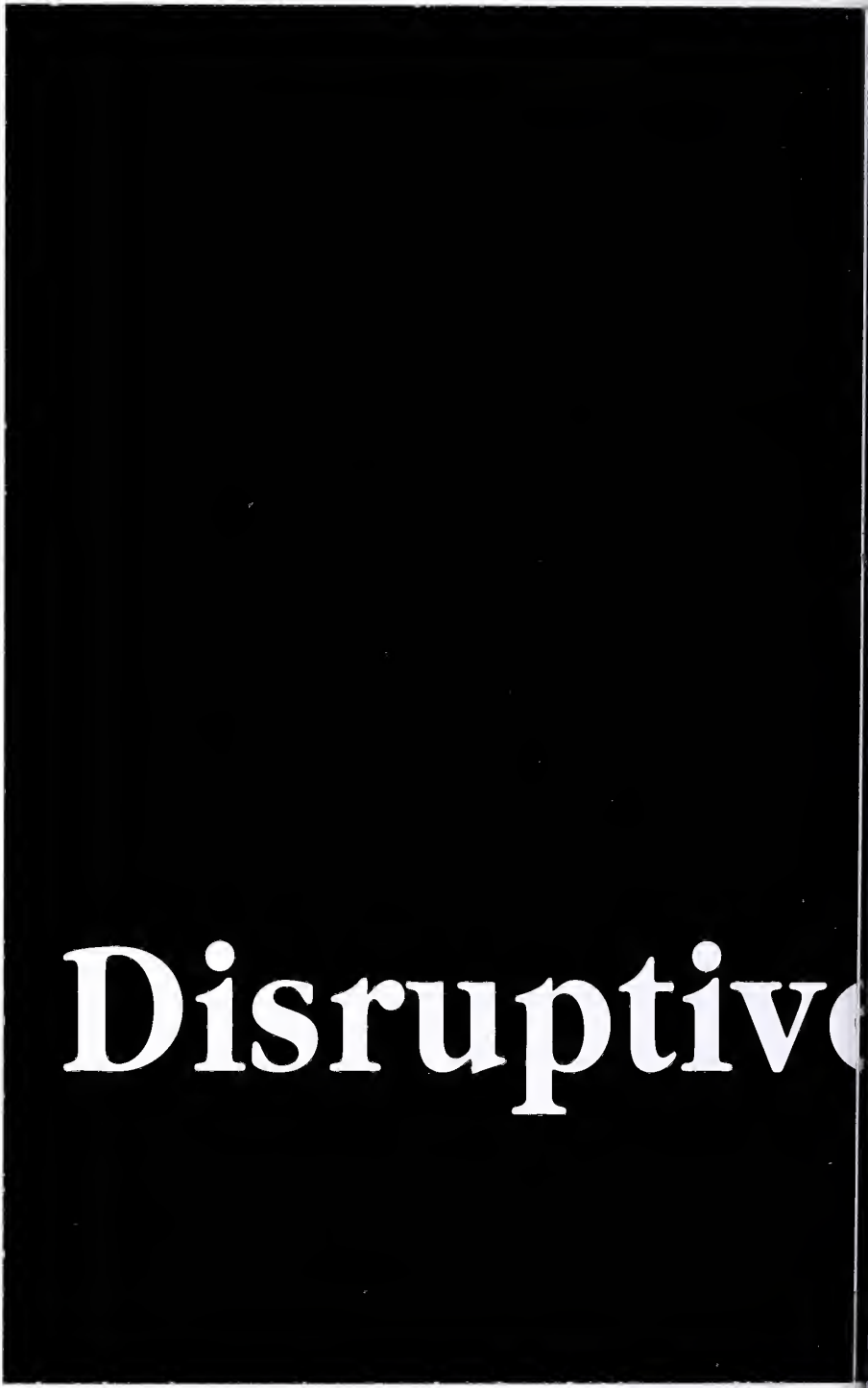
lives of victims of domestic violence? Are we truly aware of the pain behind the faces of these individuals? If we are going to stop domestic violence in Alabama we have to start face to face and make a difference one person at a time. No one person can help everybody, but each one of us can help someone.

Is the ultimate goal of AMA-ERF to increase contributions year after year? Should our goal be to encourage today's medical students by helping them financially at a very crucial time in their lives? Madison County recently gave a scholarship to a medical student who is struggling. His parents combined annual income is only $13,000. This student works as a pharmacy tech whenever he can to provide for his pregnant wife who has been diagnosed with MS. It is hard to imagine being under so mueh financial and mental stress. If we take the time to know medieal students and look at them faee to face, would we be willing to contribute willingly and freely to the American Medical Association Education and Research Foundation? Please consider making a tax free donation from your hearts this year

As state leaders we must take the first steps to develop legislative action. We must to make medical families aware that they can no longer sit on the sidelines and bury their heads in the sand! They will become victims instead of heroes as in the past. Today, we wateh our lawmakers control medicine and our futures. If we expect to see changes we must become involved. We have to be taught how to become more productive volunteers for our political leaders. When we are willing to host dinners, man phones and even empty our pocketbooks, only then will we receive the benefit of influencing our legislators to support medicine in the political arena. Face to face we will learn from Michael Dunn through his legislative workshop in January in Auburn.

All the benefits of belonging to the Medical Alliance are sometimes difficult to realize. The warmth you feel from new friends and the camaraderie that only comes from those who truly understand your lifestyle is a special benefit. Friendship is a great joy. If we take the time to encourage other physician spouses to join the Alliance we develop friendships which multiply our joys and divide our sorrows. When we fall, they encourage us to stand and help us carry the load. Friends help us savor and celebrate our victories. Take the time to look around your counties and see others who could benefit from your alliance. Look at them face to faee and share the wonderful opportunity that awaits them by joining the Alliance. ★

—Nita Maddox


Disruptiv

The medical community and the general public have, for decades, been concerned about the "impaired physician." Physician impairment, to a large extent, has focused upon substance abuse although there has also been recognition of the importance of psychiatric

physicians

disorders, particularly depression. Traditionally, medical licensure

The Disruptive Physician: The Alabama Physicians Recovery Network

Gerald L. Summer, M.D., Medical Director
Physicians Recovery Network
Medical Association of the State of Alabama
Montgomery, AL

Charles V. Ford, M.D., Professor and Director
University of Alabama at Birmingham
Neuropsychiatry Clinic
Department of Psychiatry and Behavioral Neurobiology
Birmingham, AL

William M. Lightfoot, M.D., Chairman
Alabama Board of Medical Examiners
Montgomery, AL

Reprinted from the Federation Bulletin:
The Journal of Medical Licensure and Discipline

boards charged with the responsibility of identifying dangerous physicians have investigated complaints of substance abusing physicians or professional incompetence. More recently, and associated with a greater public intolerance for various forms of sexual and verbal abuse, licensure boards have heard complaints related to physician behavior that are not necessarily directly related to issues of medical treatment. These complaints include such actions as the use of foul language, loud "rude" comments or behavior that disrupts patient care or other professional areas such as shouting, throwing medical records or instruments, intimidating staff, patients or their family members, or making sexually suggestive or offensive comments. These behaviors and others constitute a broad category of disruptive behaviors that contribute to unprofessional conduct.

Hospital administrators, nurses, employees and even patients and their families have often in the past been remarkably tolerant of outrageous physician behavior. Criticism has frequently been muted through fear of losing "high producers" or through rationalizations provided that "high strung" behavior merely reflected high stress in an overworked doctor. These poor excuses are no longer universally accepted as there has been ever-increasing awareness of how divisive and destructive such behavior can be.

This communication will focus upon the function and experience of the Alabama Physicians Recovery Network. We shall emphasize the importance of complaints related to disruptive behavior and their use in signaling the need for therapeutic interventions.

The Alabama Physicians Recovery Network

The Medical Association of the State of Alabama, in a contractual agreement with the Alabama Board of Medical Examiners (BME), developed the Alabama Impaired Physicians Committee (AIPC) in 1988 to promote the early identification of the physician who may be ill as the result of substance abuse, mental or emotional illness. The AIPC develops polieies and procedures for the impaired physicians program known as the Physicians Recovery Network (PRN). The scope of the program and reporting issues have been previously reported in the Federation Bulletin.[1]

To encourage early referral from a variety of sources, Alabama state statutes provide for confidentiality of PRN records and identity of referring sources. It has been the experience of the PRN that referral sources are less reluctant to refer to a program not identified as a part of a state regulatory agency. Following a discrete investigation, an intervention may be done with recommendations for referral for evaluation by an AIPC approved treatment provider. The PRN process is consistent with recommended guidelines developed by the Federation of State Medical Boards' Ad Hoc Committee on Physician Impairment.[2]

Categorization of Referrals to PRN

During the period October 1, 1991 through August 30, 1997, PRN received a total of 1,030 referrals. The initial behaviors prompting the referrals to PRN are categorized in Table 1.

Table 1

Initial Referral Behavior
Reported 10-1-91 through 8-30-97

Chemical Abuse	517	(50%)
Disruptive Behavior	122	(12%)
Quality Care Issues	122	(12%)
Psychiatric/Psychological	98	(10%)
Licensure Application	90	(9%)
Sexual Misconduct	67	(7%)
Indeterminate	14	(1%)
	1,030	(100%)

The abuse of controlled substances including alcohol is the primary behavior allegation received by PRN. Allegations of sexual misconduct and quality care issues, such as improperly prescribing controlled substances are promptly referred to the BME. The PRN receives referrals from the BME for out of state physicians who indicate on their Alabama state licensure application a history of chemical abuse or mental illness. Referrals suggestive of chemical abuse, mental or emotional illness, or disruptive behavior become involved in the process of investigation and intervention with possible referral for evaluation.

From the total referrals, 431 proceeded to evaluation. Table 2 categorizes the resulting primary clinical diagnosis of the referrals who were evaluated.

Table 2
Primary Clinical Diagnosis of 431 Evaluations

Chemical Dependency	236	(55%)
Chemical Abuse	28	(6%)
Affective Disorders	124	(29%)
Personality Disorder	43	(10%)
	431	(100%)

Diagnoses of chemical dependency and abuse including alcohol and other mood altering drugs, and affective disorder, including major depression, dysthymia and bipolar illness constitute the largest number of impaired physicians in the program. A primary diagnosis of an Axis II personality disorder was made in 43 (10%) of the physicians.

Allegations of Disruptive Behavior

Initial referral complaints considered consistent with disruptive behavior include sexual harassment involving employees or patients, racial or ethnic slurs, intimidation and abusive language, sarcasm or cynicism, unprofessional demeanor or conduct, late or unsuitable replies to call, and threats of violence, retribution or litigation. Referrals of disruptive behavior involve several types of complaints over a signifieant period of time and have had previous unsuccessful attempts at intervention, evaluation and treatment.

During the period October 1, 1991 through August 30, 1997, PRN received referrals of 122 physieians whose initial referral involved complaints consistent with disruptive behavior. Following investigation, many of the individuals refused or ignored recommendation for evaluation. Not infrequently, for a perceived fear of litigation or retribution, collaborative sources during the investigation were reluctant to provide necessary documentation which could be utilized to encourage an evaluation. As a result, many of the physicians in the disruptive behavior category were placed in observation pending additional referral information. Thirty-six (36) of these physicians were identified to the BME.

Table 3 categorizes the clinical diagnosis in 32 referrals with disruptive behavior who followed recommendation for evaluation.

Table 3
Categorization of Primary Clinical Impression in 32 Physicians Evaluated with Disruptive Behavior Personality Disorder*

Narcissistic	6
Narcissistic, obsessive/ compulsive features	6
Not otherwise speeified	6
Avoidant	2
Histrionic	1
Due to general medical condition	3
Bipolar Disease	2
Depression	1
Chemical Dependency	3
Situational Anxiety	1
Incomplete evaluation	1
	32

* Associated chemical dependency was revealed in 13 of these physicians, chemical abuse in 6 and 12 were given isolated diagnosis above.

It is of interest that 19 of these physicians were involved with chemicals in an abusive or dependent manner. Disruptive behavior due to a general medical condition included two with history of cerebral trauma and one diabetic physician whose self-treatment resulted in recurrent hypoglycemic episodes. Personality disorders appear to contribute to the majority of referrals with disruptive behavior. Often they self medicate in a vain attempt to control their feelings.

Psychiatric Aspects of Disruptive Behavior

The symptom of disruptive behavior can be a sign of underlying psychiatric illness. Despite popular misperceptions, psychiatric illness is at least as common in physicians as it is in the general population.[3] Fortunately, many forms of psychiatric illness, especially when identified early, are imminently treatable and do not preclude a continuation of medical practice.

Disruptive behavior can be a symptom of a number of different psychiatric disorders and/or of substance abuse/dependency. A differential diagnosis for disruptive behaviors is provided in Table IV.

Table 4

Disruptive Behavior: A psychiatric differential diagnosis

1. Substance abuse/dependency
2. Sleep deprivation/fatigue
3. Situational maladjustment reactions, e.g. concurrent multiple stressors
4. Bipolar Affective Disorder
5. Cyclothymic Disorder
6. Schizophrenia/delusional disorders
7. Dementia/delirium
8. Personality disorders

The following case vignettes illustrate the types of problems of a psychiatric nature called to the attention of the Physicians Recovery Network. The first, which had a poor outcome, may in retrospect have had a more favorable prognosis if referral had been made early and with initiation of treatment.

Dr. Y, a 59-year-old male surgeon, was identified to a hospital peer review committee because of sexual harassment complaints by hospital employees, wide variations in his mood, and failures to respond appropriately when on call. In addition, there were written reports of breaches of confidentiality regarding transmission of sensitive issues from one patient to another.

Over a period of months, Dr. Y had become garrulous with increasing religiosity and started to carry a knife strapped to his ankle. As a result of this behavior, hospital personnel felt physically threatened.

Following confrontation by the hospital chief of staff, Dr. Y located his medical practice to an adjacent state. Shortly thereafter he was admitted to a psychiatric facility but was discharged after several days. A few weeks later he committed suicide.

A much more favorable outcome of an intervention by the Alabama PRN is described below. Of note, the underlying psychiatric diagnosis is probably the same as for Dr. Y.

Dr. X, a 39-year-old thrice married and divorced male primary care physician was referred to the Alabama PRN by his HMO employer. This referral was initiated by numerous complaints made to administrators of the HMO from both patients and nursing staff. Descriptions of his disruptive behaviors included irritability and threats toward (drug seeking) patients, loud speech marked by profanity, and overt sexual advances toward female patients and staff often in the presence of others. Dr. X's employers planned to terminate him but feared legal reprisals.

Previous similar complaints had led to a prior psychiatric evaluation at an out of state facility. This consultation had focused on psychodynamic and personality issues and resulted in a recommendation for psychotherapy, with which the patient had been compliant. Unfortunately symptoms were reeurrent.

On the strong recommendation of the Alabama PRN program, Dr. X was seen in psychiatric consultation. He was eager to please and seemed genuinely perplexed and embarrassed by reports of his inappropriate behavior. He indicated a patter of years of shifting moods between depression and increased energy often associated with irritability. He provided a family history of alcoholism and Bipolar Affective Disorder.

Dr. X agreed to treatment with valproic acid (a mood stabilizing agent) and within two weeks reported significantly reduced irritability and an increased sense of well-being. Persons associated with him noted an improvement in his interpersonal relationships which he continued to address with his psychotherapist. A follow-up period of one year indicated no new complaints from either patients or staff and a stable work record that reflected good clinical judgment.

The above clinical illustrations reflect Axis I disorders. Axis II disorders (personality disorders) are more pervasive and also more difficult to treat. We shall focus on them in the subsequent communication.

Discussion

Persistent unacceptable behavior that appears to originate from immature attitudes and actions challenges the expertise of medical directors of state

physician health programs, seasoned psychiatrists, and board of medical examiners.[4,5,6] There is a strong tendency for referring sources to tolerate these behaviors despite chronicity and multiple complaints. It has been the experience of the PRN and others that disruptive behavior referrals are difficult to define in terms of evidence that could be utilized to recommend intervention and evaluation or which could sustain an action by the BME.[7] Physicians who voluntarily seek private psychiatric care are usually not involved with disruptive behavior in the professional workplace and do not usually self-medicate with controlled substances.[8] Physicians involved with disruptive behavior rarely independently seek help. These behavior referrals are identified by physician colleagues in a confidential manner or by hospital administration after several unsuccessful attempts to modify behavior resulting in fear of threats of litigation voiced as a result of the peer review committee investigation. It is common that personality disorders deny the disruptive behavior precipitating the involvement with PRN. It is the impression of PRN and other state physician health programs that the number of referrals of these physicians is increasing probably related to the rapidly changing soeio-economic and regulatory issues in the practice of medicine.

The multiple etiologies which can initially present as disruptive behavior need evaluation by clinicians experienced in working with impaired physicians. It is important to emphasize that, in the PRN experience, these behaviors were often the initial complaint that subsequently revealed chemical abuse. Physicians who self medicate with controlled or dangerous substances rarely self refer. By addressing the chemical component of these physicians' illness or personality disorder, there is more success with treatment of the primary illness. Treatment of bipolar illness in physicians, with continued monitoring of ongoing recovery, can ameliorate the pattern of disruptive behavior. Some physicians with personality disorders exhibit behavior characteristics that can be modified with appropriate therapy to conform to more acceptable behavior in the professional environment. Early identification of the behavior and referral to appropriate treatment promotes recovery of the physician and the community of quality patient care.

Conclusion

Disruptive behavior in physicians is increasingly being identified to the Alabama PRN. This communication defines disruptive behavior, presents PRN's experience and underscores: (1) the need for early identification of various conditions that can present as disruptive behavior; (2) the necessity of referral for evaluation to clinicians skilled in dealing with impaired physicians; (3) the fact that many physicians can be treated effectively without punitive action or concurrent with punitive action; and (4) the need

for a documented aftercare program to assist in preventing relapse.

Dealing with these behaviors can be difficult and time consuming and some of these physicians need to experience the legal/administrative consequences of their behavior. There is legal precedent for dealing with sensitive issues surrounding disruptive behavior in physicians.[9] However, they should all be given an opportunity for careful evaluation and treatment of their disease or personality disorder. ★

Look for another article on disruptive physicians in the next MASA Review.

References

1. Summer, GL, The Alabama Physicians Recovery Network. *Federation Bulletin: The Journal of Medical Licensure and Discipline*. 1995. 82:3:127-130.

2. Report of the Ad Hoc Committee on Physician Impairment. *Federation Bulletin*: *The Journal of Medical Licensure and Discipline*. 1994. 81:4:229-242.

3. Watterson, DJ, Psychiatric Illness in the Medical Profession: Incidence in relation to sex and field of practice. Am Med Assoc J. 115:311-317, 1976.

4. Vanderberry, RC, North Carolina Physicians Health Program. Personal communication.

5. Dodd, D, Tennessee Impaired Physicians Program. Personal communication.

6. Benzer, DO, Miller, MM, The disruptive physician: A new look at an old problem. Wis Med J 94(8):455-460, 1995.

7. Donald, LJ, Doctors with Problems in an NHS Workforce. BMJ 308:1277-1289, 1994.

8. Stratas, NE, The Contrast Between Physicians Seen by the Medical Board and Those Seen in Medical Practice. NCMJ 57:218-221, 1996.

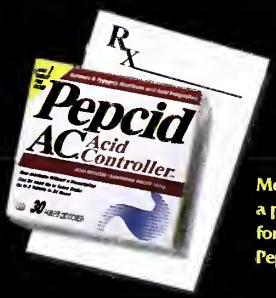
9. William, L, CRNA, JD. Cited in legal briefs. Jr. AANA, 63:377-379, 1995.

Pepcid AC Acid Controller.
ACID REDUCER / FAMOTIDINE TABLETS 10 mg

Covered by Alabama Medicaid

FREEDOM FROM THE HIGH COST OF HEARTBURN

• **Pepcid AC®**	**$0.28 per dose[1]**
• Ranitidine 150 mg	$1.48 per dose[1]
• Prilosec®* 20 mg	$3.59 per dose[1]



Medicaid requires a prescription for coverage of Pepcid AC 10 mg

*Prilosec (omeprazole) is a registered trademark of Astra Merck.
1. Sources: IRI, November 1997; *Red Book Update*, November 1997; IMS America, September 1997.

© Johnson & Johnson & MERCK Consumer Pharmaceuticals Co., 1998 ® Registered trademark of Merck & Co., Inc

JVMC-1139 2/98

confrontation credits: one key to motivation

Peter A. Land

As a supervisor it is your job to keep your employees motivated. If the truth were known, you really can't motivate your employees. The only true motivation is self-motivation, but you can and must create a positive environment or atmosphere around all employees so they will personally assess the environment in such a way that creates self-motivation in their minds.

Sounds complicated, doesn't it? Well, it is! There's nothing more complex than human behavior.

Before you put "motivation" in the "too tough pile" and give up, I want to share a valuable skill with you to help you create self-motivated employees.

Think of your relationship with each of your subordinates as an "emotional bank account." As with most bank accounts, we routinely make deposits and withdrawals. The greatest "no-no" with any bank account is becoming overdrawn.

There is a parallel in dealing with people. You make deposits with people when you provide positive reinforcement, praise, recognition, or simply treat them with dignity and respect.

Emotional withdrawals are made when you criticize inappropriately, rebuke, embarrass, or otherwise make them feel insignificant and of low self-esteem. Even confronting honest mistakes results in a withdrawal.

As a supervisor your praise is valued by your subordinates; they willingly accept deposits when you go to the trouble to make them. Let's assume you realize that people don't do jobs - they do tasks. Jobs are made up of an array of tasks. It's the many tasks they actually do in order to get the job aeeomplished.

Let's further assume you appreciate the fact that most people do most tasks very well most of the time. You value your employees and notice the good work they are doing daily. You take a moment each day to sincerely thank them, comment about some task they did better, quicker, cheaper, neater, sooner, etc. You've made some deposits with your employees. You have established some "positive confrontation credits" with the people who value them the most.

Then - ooops - someone makes a mistake. It's also your job as a supervisor to deal with (confront) deviations. So you speak to the errant employee in private, describe the error in objective terms, seek the reason rather than assign blame - generally correct the situation with dignity

and class. You've just made a withdrawal: it's your job.

Great managers deal positively with the deviations in a timely manner so standards and pride are preserved, but they never overdraw! Oddly enough, an employee's overall attitude, morale, and motivation are not influenced so much by the last transaction, but by the running balance. If you've built up sufficient positive confrontation credits by sincerely reinforcing your employees, then confronting occasional deviations does not overdraw your emotional account with the people who look to you for leadership.

So there you have it, a simple but effective way to help create an atmosphere that results in self-motivated employees. Your interest in this emotional bank account will pay great dividends. ★

Medical Director
Alabama Physicians Recovery Network

The Medical Association of the State of Alabama is seeking a medical director if its impaired physicians program. PRN has provided for a full time medical director since 1991, is fully developed, nationally recognized and has stable funding. Interested applicants should be familiar with the special issues of physicians involved with substance abuse and have a working knowledge of affective illness and personality disorders. Applicants must have strong interpersonal communication skills. Please send CV and request an application for the position to:

Gerald L. Summer, M.D.
19 South Jackson Street
Montgomery, AL 36104

VOLUNTEER OPPORTUNITIES FOR PHYSICIANS

by Arthur A. Stamler, M.D.

Numerous organizations exist for the purpose of assigning physicians to medical volunteer positions around the world. There is an enormous need for medical expertise in many places, which is never-ending. For many, life is an almost hopeless turmoil, interspersed with disease, hunger, poverty and political confusion. American physicians can do much to mitigate these ravages. The wages are in what is received in return - love, affection, thanks. There is nothing else to give.

Within every caregiver I've ever met lies a desire to go someday to a far place and practice solely for the joy of giving something away. This is one of the purest forms of charity. Many of the patients have never been to a health professional of any sort in their entire lives. When disease, blindness, disfigurement and more strike, there may be no one else to offer relief except volunteers from afar.

The following listing is far from complete, but does include many agencies and organizations which will assist the willing physician in locating an assignment. Some have phone numbers listed. Most offer hands-on care; others specialize in environmental control, immunizations, and providing teaching services. Some offer stipends; inquiry is suggested. Assignments vary from a few days to career-length. Personal expenses are usually tax-deductible.
Applications made well in advance are recommended, a year is not too long. Questions to ask include necessity for passports, possibility of family members accompanying (and working), need for malpractice insuranee (covered in most cases by the organization, and in most cases not required), need for immunizations, and transportation.

Organization	Address	Phone	Comments
Accion/Aitec	10-C Mt. Auburn St. Cambridge, MA 02138	(617) 492-4930	
Action International Ministries	PO Box 490 Bothell, WA 98011	(206) 485-1967	Philippines
Adventist Development and Relief Agency International	6840 Eastern Ave. NW Washington, DC 20012		
Aesculapian International	PO Box 1319 Santa Barbara, CA 93102		Most specialties; worldwide
Africare	1601 Connecticut Ave. NW Washington, DC 20009	(202) 462-3614	Long and short term
Aid for International Medicine	1828 Wawaset St. Wilmington, DE 19806	(302) 655-8290 (302) 654-5848	Africa, Asia, South America
Air Commando Association	PO Box 7 Mary Esther, FL 32569	(904) 243-4601	Guatemala, one month minimum, pediatrics
AM-DOC/Option	3502 Hancock St. PO Box 81122 San Diego, CA 92138		Acts as information clearinghouse for US; worldwide
American Academy of Pediatrics	Department of Community Pediatrics 141 Northwest Point Blvd. Elk Grove Village, IL 60007	(800) 388-4702	Worldwide, pediatricians - some volunteers, some paid
American Council of the Ramabi Mukti Mission	PO Box 4912 Clinton, NJ 10010	(212) 735-8770	
American Jewish World Services	15 West 26th St. New York, NY 10010	(212) 683-1161	Worldwide; most specialties
American Medical Assocaiton	Project USA 515 N. State St. Chicago, IL 60610	(800) 388-4702	Rural US
American Medical Student Association	1890 Preston White Dr. Reston, VA 22091	(703) 620-6600	Medical students and residents
American Near East Refugee Aid	1522 K St. NW Suite 202 Washington, DC 20025		
American ORT Foundation	817 Broadway New York, NY 10003	(212) 677-4400	
American Red Cross	17th and D Streets Washington, DC 20006	(202) 737-8300	
The Americas - Hand in Hand	PO Box 424 Billings, MT 59103	(406) 245-7426	Short term, 2-52 weeks
American Public Health Association International Health Programs	1015 15th St. NW Washington, DC 20005	(202) 789-5600	Worldwide, few weeks as consultants
American Refugee Committee	2344 Nicollet - Suite 350 Minneapolis, MN 55404	(612) 872-7060	Asia
Americares Foundation	51 Locust Ave. New Canaan, CT 06840	(203) 966-5195	Asia, Africa, Latin America - term of service varies

Organization	Address	Phone	Comments
Amigos de las Americas	5618 Star Lane Houston, TX 77057	(713) 782-5290	Latin America; 4-8 weeks in summer
Brother's Brother Foundation	PO Box 6067 Pittsburgh, PA 15211		Rescue operations in natural disaster; immunizations
CAM International	6825 La Prada Drive Dallas, TX 75228	(214) 327-8206	Central America; Spain - mostly short term
Canadian University Services Overseas	151 Slater St. Ottawa, Ontario K1P 5H Canada		
CARE - Medico	2007 Eye St. NW Washington, DC 20006		Central America, Middle East, Asia, Africa - short and long term volunteers, especially orthopedics
Catholic Medical Mission Board	10 West 17th Street New York, NY 10011	(212) 242-7757	Worldwide - short and long term
Catholic Relief Services	1011 First Ave. New York, NY 10022	(212) 838-4700	
Christian Medical Society	PO Box 689 Richardson, TX 75080		Worldwide, most specialties
Christian Medical College Board USA	475 Riverside Drive New York, NY 10155		India, short term only
Claretian Volunteers	4501 South Ashland Chicago, IL 60609	(312) 247-3325	Guatemala
De Pauw University	Winter Term in Mission Chaplain's Office Greencastle, IN 46135	(317) 658-4619	One month in January each year
Direct Relief Foundation	PO Box 1319 Santa Barbara, CA 93102		Worldwide and US
Direct Relief International Volunteer Services	PO Box 30820 Santa Barbara, CA 93130-0820	(805) 966-9149	
Doctors of the World	625 Broadway, 2nd Floor New York, NY 10017	(212) 687-3620	
Esperance, Inc.	1911 West Earll Dr. Phoenix, AZ 85015		Brazil, 3 weeks, surgeons only
Eye Care, Inc.	523 Eighth St. SE Washington, DC 20003	(202) 544-4700	Haiti; opthalmologists only
FOCUS, Inc.	Department of Opthalmology Stritch School of Medicince Loyola University 2160 S. First Ave. Maywood, IL 60153	(312) 531-3408	Opthalmologists only
Global Outreach	PO Box 1 Tupelo, MS 38802	(601) 842-4615	Haita, Uganda - general practitioners and internists
Heal the Children	PO Box 6051 Spokane, WA 99207-5157	(202) 296-0928	Worldwide - pediatric speeialists

VOLUNTEERING

Organization	Address	Phone	Comments
Health Volunteers Overseas	c/o Washington Station PO Box 65157 Washington, DC 20035-5157	(202) 296-0928	Worldwide - most specialties
Hospital Albert Schweitzer	150 Kennedy Drive South Burlington, VT 05403	(802) 862-7503	Haiti - one month minimum
International Lifeline	PO Box 32714 Oklahoma City, OK 73123	(405) 728-2828	Haita, Tanzania, Kenya - 2-8 weeks (no longer) - general practitioners, obstetricians, pediatrics
International Medical Corps	10880 Wilshire Blvd. #2008 Los Angeles, CA 90024	(310) 670-0800	Worldwide - most specialties
International Program Development Center	55 Chapel St. Newton, MA 02160	(617) 969-7100	Physicians are hired as consultants (salary) - two weeks-one year
Interplast	378-J Cambridge Ave. Palo Alto, CA 94306	(415) 329-0670	Plastic and reconstructive surgeons, pediatricians - short term
Helen Keller International	15 West 16th Street New York, NY 10011	(212) 620-2100	Worldwide - opthalmologists, pediatrics, public health
La Buena Fe Association	PO Box 2 Independence, MO 64051	(816) 229-9252	Honduras - two weeks, health teams
LBJ Tropical Medicine Center	Pago Pago American Samoa 96799	(684) 633-2732	3-12 months plus stipend
Lutheran World Relief	360 Park Ave. New York, NY 10010	(212) 532-6350	
MAP International	Mrs. JR Knighton Box 50 Wheato, IL 60187		Developing countries
Marimed Foundation	1050 Ala Moana Blvd., Bldg. D Honolulu, HI 96814	(808) 537-5586	Hospital ship to Micronesia, seven Marshall Islands - three months minimum
Medical Group Missions Christian Medical Society	1122 Westgate Oak Park, IL 60301		Carribbean, Liberia - short term and long term
Mission to the World	PO Box 1744 Decatur, GA 30031	(404) 292-8345	Worldwide, long and short term - general practitioners and obstetrics
National Council for International Health	2121 Virginia Ave. NW Washington, DC 20037	(202) 298-5905	Most specialties - short and long term
Orthopedics Overseas	PO Box 57465 Washington, DC 20525	(202) 466-6106	Worldwide - orthopedics

Organization	Address	Phone	Comments
Peace Corps/ACTION	806 Connecticut Ave. NW Washington, DC 20525	(800) 424-8580, ext. 84	
Physicians for Peace	229 West Bute St., Suite 820 Norfolk, VA 23510	(804) 625-7569	Worldwide - most specialties
Project Concern	PO Box 81123 San Diego, CA 92138		US and abroad
Project Hope	Health Science and Education Center Millwood, VA 22646		Worldwide - primary goal is improvement of health conditions - long and short term
Project Orbis	330 West 42nd St. #1900 New York, NY 10036	(212) 244-2525	Flying eye hospital staffed by ophthalmologists - four week minimum
Remote Area Medical Volunteer Corps	1834 Beech St. Knoxville, TN 37920	(423) 579-1530	Western hemisphere, Appalachian - 3-14 days and weekends
Rescue Now	870 Market St., Room 1050 San Francisco, CA 94107	(415) 433-3055	Guatemala, El Salvador and Somalia - two week terms
Southern Baptist Conference	Foreign Mission Board PO Box 6767 Richmond, VA 23230		Worldwide - most specialties
Surgical Eye Expeditions, International	1216 State St., Suite 310 Santa Barbara, CA 93101	(805) 963-3303	Worldwide - opthalmologists - 3-14 days
Volunteer Optometric Services Humanity	PO Box 310 Rolla, MO 65401	(314) 364-1773	Ophthalmologists - short terms - mostly Latin American and the Caribbean
World Gospel Mission	Box WGM Marion, IN 46952	(317) 664-7731	Kenya, Honduras - two week term
World Relief Corporation	PO Box 2836 Washington, DC 20013		
World Witness Board of Foreign Missions for the Associate Reformed Presbyterian Church	1 Cleveland St. Greenville, SC 29601	(864) 233-5226	Pakistan - two week minimum

masa services

THIRD PARTY TASK FORCE

The Third Party Task Force is a committee of MASA which consists of physician members who provide assistance to other physicians in resolving issues and disputes with insurance companies, HMOs, other third party payors, including Medicaid and Medicare, and other peer review organizations. Member physicians requiring the assistance of the Task Force should send a letter detailing the nature of the dispute and copies of relevant correspondence or medical records to MASA. *Contact: Wendell Morgan 1-800-239-6272*

PHYSICIANS RECOVERY NETWORK

The Physicians Recovery Network promotes the early identification, evaluation, and treatment of physicians who may be impaired as a result of mental/emotional illness, or substance abuse/dependence. A documented program of recovery is offered to enable these physicians to return to practice. The PRN staff is available to present several educational programs suitable for all audiences. *Contact: Jerry Summer, M.D., 1-800-239-6272*

COLLECTION AGENCY

One of the biggest problems for physicians is collecting fees owed to them by patients. Keeping costs down and cash flowing are critical factors in the success of any practice—fiscal soundness is a must, and physicians need an effective collection agency to assist them in recovering delinquent accounts such as I.C. Systems, Inc. *Contact: I.C. Systems, Inc. 1-800-685-0595*

GOLD MASTER CARD PROGRAM

Your MASA membership entitles you to participate in this outstanding credit card program, featuring a credit line up to $15,000, no first year annual fee and an annual fee of only $30 after the first year. *Contact: MBNA 1-800-847-7378 Ext. 400*

MAGAZINE SUBSCRIPTION PROGRAM

MASA members can take advantage of low subscription rates for a tremendous array of popular and specialty magazine, which include *TIME, The New Yorker, US. News & World Report, Vanity Fair,* and *Better Homes and Garden. Contact: Subscription Services, Inc. 1-800-289-6247*

TRAVEL AND HOTELS

MASA has made arrangements with Destinations Quest International Hotel Savings Program to enable you to enjoy savings of up to 50% off standard hotel rates and up to 25% discount on many hotel restaurants at more than 2,100 top quality hotels. *Contact: MASA 1-800-239-6272*

LONG DISTANCE TELEPHONE SERVICE

DeltaCom was chosen to offer a program to physicians because of their commitment to personalized customer service, simplicity of billing statements, as well as DeltaCom's unique ability to customize business long distance accounts. *Contact: DeltaCom 1-800-239-3719*

TAX AUDIT DEFENSE

TaxResources, Inc., the pioneer and largest Tax Audit Defense firm in the U.S. brings to our Association physician members the specialized abilities of over 500 hand picked and specifically trained IRS agents, auditors, and tax attorneys. *Contact: TaxResources, Inc. 1-800-922-8348*

PROFESSIONAL LIABILITY AND OTHER TYPES OF INSURANCE COVERAGE

Coverage is available through Mutual Assurance, Inc. of Birmingham, the largest writer of liability insurance for physicians in the state. Mutual Assurance was formed by MASA during the insurance crisis of the mid 1970's, when liability coverage was suddenly not available to Alabama physicians. Mutual Assurance, Inc. also offers other types of insurance coverage such as disability, life, business overhead. *Contact: Mutual Assurance, Inc. 1-800-282-6242*

HEALTH INSURANCE COVERAGE

MASA endorses Blue Cross Blue Shield group health insurance plans for you and your staff.
Contact: Emmett Wyatt, MASA 1-800-239-6272

PRACTICE MANAGEMENT RESOURCES

United Communications Group offers newsletters and other publications to help physicians, including: Part B News, Part B Answer Book, Practice Strategies for Managed Care, Physician Practice Coder, RBRVS FeeCalc software, Medicare Compliance Alert and Physician Office Lab News. Exclusive MASA discount available.
Contact: United Communication Group, 1-800-929-4824, Ext. 2238

Buying A Computer

By Brad Frisbie, M.D.

At Point Clear, I gave a lecture on the parts of a computer and understanding how they work together. During this next year of MASA Review, I would like to discuss how they can help you be productive in your personal and professional lives. We can begin by discussing the different approaches to buying a computer. Each will reflect one's personal philosophy, level of time commitment, and basic understanding of the components involved.

Local Vendors

There are three different ways you can buy a computer. The first is perhaps the easiest and most painless and involves buying from a store which sells computers in your area. Local vendors include CompUSA, Radio Shack, Circuit City, Service Merchandise, and even Sears. These big retail stores generally only carry computers that are manufactured from large companies that are "name brands" such as Compaq, Packard Bell, Dell, Gateway, and Hewlett-Packard. There are several advantages to buying a computer from a local vendor. First, you can see what you are buying and expose yourself to the knowledge of a sales rep personally which is ideal if you do not have a basic knowledge of the components. They will anticipate what extras you will need with a few simple questions. Second, if something goes wrong, technical support is a short drive or phone call away and the merchandise can easily be returned if you are dissatisfied. Third, these companies screen their computers to have a minimum of problems, the highest reliability, and the best performance for the components contained inside their machines. Lastly, many will offer computer classes that will teach you how to use your computer and the most popular forms of software.

The main disadvantage of buying from a local vendor is that it is the most costly, ranging from a few hundred to a thousand dollars more than buying through other methods. You are paying for advertising, showroom floors, expanded technical support, and a high merchandise return rate. While technical support is easily accessible, it is usually inferior to what one obtains by calling the manufacturer. I have found more often than not that the support staff at these local vendors have only the bare minimum knowledge necessary to sell their products

There are also a variety of mom-and-pop stores which you can find in the Yellow Pages. They acquire inex-

pensive components and assemble them into fully working computers capable of all of the tasks of their more expensive counterparts. They have better technical expertise and offer the accessibility of a name brand local vendor. If they go out of business, so does your support.

Mail Order

There are a variety of ways you can approach purchasing a computer by mail. There are literally thousands of vendors with websites on the Internet. The advantage of advertising on the net is that it is nearly free. My assumption is that you do not have a computer or are not savvy about where to find these sites, and so my favorite method is to pick up a computer magazine and merely thumb through the ads. The premier repository for computer sales is the Computer Shopper, a monthly magazine costing $4.95 and available at any bookstore or large grocer with a magazine rack. Here you will find computers offered by a variety of manufacturers. Some will be large companies (Dell, Gateway, Micron). Some will be medium-sized (Quantex, Royal, Everex). And some will be small (Bob's Computers and Chainsaw Repair).

The main advantage to buying by mail is that it is much less expensive. You are not paying for showroom floors or distribution costs nor are you subject to state sales tax. The technical support is generally better but accessibility is reflected in the size of the company and the aggressiveness of their prices. Name-brand companies with more costly products have great tech support. Small companies are overrun with telephone calls. I have often waited a week for a technician to return my call. The pivotal take-home point here is that the vast majority of computers offered by large and medium sized companies have nearly identical components and reliability does not appreciably differ with local vendors until you begin to deal with the very small companies (found in the last third of most computer magazines).

The disadvantage of buying mail order is the inconvenience of returning a product in case something should go wrong. This will involve repacking the computer and mailing it back at an average cost of $75-$125 to you - the company rarely picks up the tab even if it is their fault. I recommend keeping all boxes and styrofoam until your warranty expires. Buying mail order will mean that you do not know what you are getting until you unbox it. While I have occasionally returned components, I've never returned an entire computer because it didn't work or was aesthetically unpleasing.

Epilogue

When you have made the decision to buy a computer, pickup a current copy of Computer Shopper and systematically look at the first 100-200 pages of advertisements. Even if you know nothing about computers, you will develop an intuition about what is currently state- of-the-art, and this will help you regardless of your decision to buy through a local vendor or by mail order. Then you must ask yourself, "Do I really need a computer? What the heck am I going

to use this thing for?" I hope to answer this question in depth in the next article but a simple self-assessment is in order:

1. My needs are simple. If you just want to use a computer for balancing a checkbook, word processing, maintaining to-do lists and telephone lists, and email only, any generation of computer manufactured in the past four years will do. A used 486 CPU-based machine will cost you $200. A new 586 (Pentium) with a 166 MHz processor can be obtained for less than $600. I personally have three computers, one of which is an old 486 which performs the majority of my home management tasks quickly and efficiently.

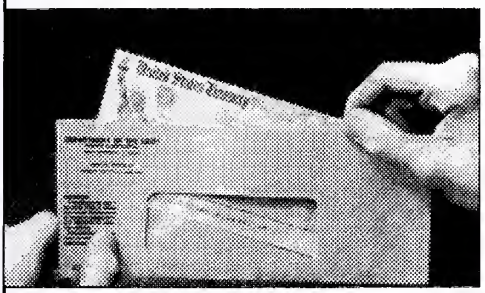
2. My needs are average. If you want to be able to connect to the Internet and view its multimedia format, create and manipulate a database for patients in your office, last year's computers will be more than sufficient. A Pentium 200-300 MHz system will cost $1000-$1500.

3. My needs are complex. If you have teenagers that desire to play the latest games, you desire to do voice dictation, you plan your purchase for the simultaneous use of several office staff at different monitors or are aware that the movie industry is moving away from video tape to DVD-ROM and wish to use it for viewing movies, you should get the latest on the market. This will set you back $2000-$2500 but will buy you the flexibility to withstand the winds of time for the next several years.

Consider also buying the largest monitor your budget will allow - no less than 17 inches. A scanner and printer is a must in the medical field and will add $500 to buy a quality pair. Lastly, the slant of this article has given the nod to the IBM-based line of computers as this represents the majority of the market share and the easiest access to community support. If you know absolutely nothing about computers and are willing to pay a little more for a comparably capable machine, consider buying Apple's Macintosh. Ease of use, aestheties, and reliability are unrivaled but you may have to ask around to find enough friends who own them to get any answers to questions you may have. Any questions? You can reach me at frisbie@wwisp.com. ★

COULD YOU USE AN EXTRA $10,000?

The Army Reserve will pay you a yearly stipend which could total in excess of $10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP) if you are a resident in: thoracic surgery, peripheral vascular surgery, orthopedic surgery, neurosurgery, urology, diagnostic radiology, emergency medicine or internal medicine.



Once you complete your residency you will have opportunities to continue your education and attend conferences. Your commitment in the Army Reserve is generally one weekend a month and two weeks a year or 12 days annually.

Get a maximum amount of money for a minimum amount of service. Find out more by contacting an Army Reserve Health Care Recruiter. Call:

770-960-7640

ARMY RESERVE MEDICINE.
BE ALL YOU CAN BE.®
www.goarmy.com

upcomin

1998

NOVEMBER

November 7
Pediatric Asthma Update 1998
Birmingham, AL
Contact: Cindy Atkins (205) 939-9583
CME Credit: 4 hours Category 1

November 7
6th Annual Shoals Cardiology
Florence, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490
CME Credit: 6 hours Category 1

November 7
Alzheimer's Upate
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490
CME Credit: 6 hours Category 1

November 13
10th Annual Infectious Disease
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490
CME Credit: 7 hours Category 1

November 14-15
The Promise of Telecommunications & Computers
Fairhope, AL
Contact: Alabama Academy of Family Physicians (800) 239-6272

November 17-18
MASA Board of Censors
Montgomery, AL

DECEMBER

December 2
Developing a Compliance Plan That's Right for Your Practice
Contact: MASA Education Dept.
(334) 263-6441 or 1-800-239-6272
Montgomery Museum of Fine Arts
Montgomery, AL

December 3
Developing a Compliance Plan That's Right for Your Practice
Contact: MASA Education Dept.
(334) 263-6441or 1-800-239-6272
The Wynfrey Hotel
Birmingham, AL

December 4-5
The Dermatology Course: An intensive two-day review for Primary Care Physicians
Birmingham, AL
Contact: Alabama Academy of Family Physicians (800) 239-6272

December 5
Developing a Compliance Plan That's Right for Your Practice
Birmingham, AL
Contact: MASA Education Dept.
(334) 263-6441 or (800) 239-6272

December 5-9
AMA Interim Meeting
Honolulu, Hawaii

December 15-16
MASA Board of Censors
Montgomery, AL

events

1999

JANUARY

January 15
The HIV Patient in Your Practice
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

January 19-20
MASA Board of Censors
Montgomery, AL

January 23
Fifteenth Invitational Scientific Symposium
Birmingham, AL
Contact: MASA Education Dept.
(334) 263-6441 or (800) 239-6272

January 26-27
AMASA Winter Board Meeting
Auburn, AL

January 31 - February 2
MASA Governmental Affairs Conference
Washington, D.C.
Contact: MASA Governmental Affairs Dept. (334) 261-2000 or (800) 239-1333

FEBRUARY

February 3-6
Adolescent Medicine Seminar
Lake Buena Vista, FL
Contact: George M. Converse, M.D.
(205) 783-5276
CME Credit: 15 hours Category 1

February 16-17
MASA Board of Censors
Montgomery, AL

February 20-25
Piñata of Pediatrics XI
Costa Rica
Contact: UAB CME Office - Huntsville
(256) 551-4490
CME Credit: 12-15 hours

MARCH

March 2
Legislative Session Begins

March 5-6
MASA Leadership Conference
Birmingham, AL
Contact: MASA Education Dept.
(334) 263-6441 (800) 239-6272

March 9-12
15th National Symposium on Child Sexual Abuse
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

March 13
1999 Asthma & Allergy Update
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

March 14-17
Internal Medicine Seminar
Lake Buena Vista, FL
Contact: George M. Converse, M.D.
(205) 783-5276
CME Credit: 15 hours Category 1

March 16-17
MASA Board of Censors
Montgomery, AL

March 17-20
Family Practice Seminar
Lake Buena Vista FL
Contact: George M. Converse, MD
(205) 783-5276

Q: I always direct my patients to call me to obtain the results of their tests. Often they don't call, and I'm concerned that I may be hit with a malpractice lawsuit even though I've explained to them the importance of getting their test results. Are there accepted guidelines for dealing with abnormal test results?

A: You're walking through a malpractice minefield! Unfortunately you're not alone; more than one-third of the physicians responding to a recent government survey said they don't routinely notify patients of abnormal results. Most of the those respondents said they wait for a follow-up visit to discuss test results, yet two-thirds said they have no system in place to track whether patient appointments are kept. Those statistics explain why this one area of medicine generates the largest number of lawsuits.

Mutual Assurance urges physicians and their office staff to adopt an effective system of patient tracking and follow-up that revolves around the three "C's" - commitment, consistency and centralization.

Commitment to the concepts and components of an effective tracking system must be present at all levels and stages of the process. Consistency can be achieved through the use of a follow-up log, which allows for recording and processing of all lab or diagnostic studies which are performed. These results can then be monitored and reviewed on a periodic basis to assure that all results are received in a timely manner.

Another aspect of the follow-up procedure involves review of the findings. All test results and labwork should be reviewed by the physician. Following the review the physician should initial the report and make notes in the patient record regarding disposition of the issue and method of communication with the patient.

When abnormal results occur, the patient should be contacted personally by the physician. This contact should be documented in the patient's medical record, with a note as to the instructions given and the patient response. If all other attempts at reaching the patient fail, a certified letter should be sent by US Mail with appropriate documentation in the chart as well. If the letter is returned, it should be filed, unopened, in the patient record with the date of its returned noted. Where additional follow-up is required or recommended, the information should be reintroduced into the tracking system so that further follow-up can be accomplished.

When patients are non-compliant, it is even more important to thoroughly and timely document the facts in the patients' medical record. No-shows for office, diagnostic study or referral appointments should be carefully recorded in the patient record and appropriate attempts should be made to contact the patient and urge compliance or rescheduling. Such efforts should be documented. These efforts at thorough and accurate documentation would be critically important in the lawsuits where patients steadfastly maintain that no attempt was made to notify them.

Centralization involves the appointment of one person in the office setting to be ultimately responsible for the effective and efficient operation of the system. While all employees need to be educated about the system and their personal roles in supporting and maintaining the system, one person must have ultimate responsibility for its operation. This person will quite literally be the link between patients with potentially life threatening conditions and their timely recognition and treatment.

Physicians interested in learning more about the need for such a system, or having an office-based seminar on this important topic may contact Mr. Tom Phelps, Vice President for Loss Prevention Services at Mutual Assurance, (800) 282-6242 or 877-4400 in Birmingham. ★

We welcome your risk management or malpractice related questions. You may send them to Amanda Jones at MASA, amanda@masalink.org or 1-800-239-6272; or to Tom Phelps at Mutual Assurance, P. O. Box 590009, Birmingham, AL 35259-0009. Mutual Assurance also provides general risk management assistant for its insureds through its no-cost resource center at (800) 282-6242 or 877-4400 in Birmingham, or on the web at www.medicalassurance.com.

The need to have a sound tracking system is illustrated by the following:

A general practitioner ordered an x-ray for a 39-year-old female who presented to him with unexplained breathing difficulties and coughing. The radiologist noted in his report that she had a "suspicious lesion in the right lobe, which warrants additional views to rule out a neoplasm."

When the physician's receptionist received the report, she filed it in the patient's record because she knew the patient was scheduled for a follow-up visit the next week and assumed the physician would review it then. However, the patient never returned; she lost her job and abruptly decided to move out of town. The physician did not discover the report until two years later when the "suspicious lesion" had emerged as cancer and the patient brought suit against him resulting in the loss of several hundred thousand dollars.

How should a medical practice administrator open a series of articles for physicians about practice management? Since we're dealing with a physician/administrator team, the place to begin is with the relationship of the physician and the administrator. From personal experience, this is "make or break" for the effectiveness of that team. As a way of explaining, I've written this open letter to you, the physician.

By Dan Bailey

DEAR PHYSICIAN,

During the almost ten years that I have been a medical group administrator, the best and most rewarding recognition I have received has come, similarly on two separate occasions, from two different physician partners in our group when they have introduced me to medical colleagues as their non-physician business partner. Obviously, in the world in which we work as physicians and medical administrators, they were not describing a legal corporate relationship, but rather an attitude of trust and empowerment that communicated that for at least that moment we were getting it right.

Let me hasten to add that neither our physicians nor I would want to leave you with the impression that it is always that way. I have always enjoyed the scene in an old Jimmy Stewart western, the name of which I have long since forgotten, where a young man has the unenviable task of asking for Jimmy's daughter's hand in marriage. Like most starry eyed young men, this one goes on and on as to how much he loves the daughter only to have Jimmy Stewart bring him back to sobering reality by saying "I know you love her, but do you like her?" To describe the reality of our own physician /administrator team I would simply change the question to ask, " I know you like him, but do you trust him/her?"

The reality is that on any given day, as we struggle to find the right answers for our practice while at the same time having to juggle a myriad of individual agendas, we may sometimes get to a moment where we aren't sure if we even like one another. However, to be effective in dealing with critical management issues and decisions there must never be a moment when we don't trust each other's talents and commitment to the team. A successful professional relationship, much like a marriage, is a moving target. It requires constant change and attention. The key to hav-

ing an effective physician/administrator team is for those exceptional moments of partnership to become the rule rather than the exception.

Like you as physicians, medical group administrators and practice managers eome from a variety of backgrounds, education and training. Among my own group of trusted peers are persons who in their careers have literally grown up in their medical office to the point they now have management responsibilities. Others chose this as a special career path and earned advanced degrees specifically in this field. Still others, like me, came at the invitation of some trusted friend, from some other discipline or training entirely unrelated to medicine or management. My own background and training is in a far different field from the one where I now labor, but it is in an area that taught me a great deal about relationships, the importance of good communication and the ability to step back and see the big picture. The physicians with whom I have worked for nearly ten years know me even before I began to work there, and so we had the advantage of personal trust and friendship from the start. The physicians patiently guided me through that early time when then only thing I knew about medicine was what I had experienced as a patient. (I can make the case that this may be the best perspective to bring to medical management). In return, I have helped to guide them through growth and the kinds of change you all know well.

I believe that one of the most harmful myths within the medical community is that physicians are poor managers. I hear it said often by advisors, and sometimes by employees who perhaps stand to benefit most by convincing physicians that the myth is true. Something of a self-serving prophecy. The truth of the matter is that you make critical management decisions every day as part of providing medical care. The ability to make a specific diagnosis from multiple choices, the ability to manage a vast array of resources to treat an illness and to communicate in layman's language things that are really far to complex for most of us to understand these are clear evidence that physicians have adequate if not excellent management skills. I have worked closely with wonderfully gifted physicians and surgeons who, when they have the time, are also insightful managers and business people. The truth of the matter is that any of you who have earned an MD degree and passed your boards could certainly earn an MBA, JD or any number of other degrees outside of your chosen profession having already clearly demonstrated both the intellect and self discipline to accomplish the task. In my activities across the state, I am constantly running into managers who lament that they don't know what their physicians expect of them. While at the same time, I hear physicians saying that they aren't sure they

are getting what they think they need from their managers. Being the meddlesome, relationship-oriented person that I am I will often ask, "have you talked about it?" It is amazing how often the answer is No! The truth of the matter is that effective physician/administrator teams will have unique differences between themselves and others, but there are three common threads that I believe are always present - communication, trust and empowerment.

Contrary to the myth of the physician as poor manager, I submit that the evolution of medical practice management to its current level of professionalism is evidence that physicians are, effective managers and decision makers.

Contrary to the myth of the physician as poor manager, I submit that the evolution of medical practice management to its current level of professionalism is evidence that physicians are effective managers and decision makers. You have recognized and created the need for the non-physician player on the practice management team. It is not a question of your abilities, but of priorities. The first step on the path of achieving a highly effective physician/administrator team is for the manager/administrator to realize and accept that it is not that you cannot do the job. Rather it is that you trust us to do the job so that you can give your full attention to doing what you are uniquely trained and called to do. That reality alone should provide sufficient motivation for any manager/administrator to be the very best that they can be in their given situation. But, you have to communicate that trust and then step back and act accordingly. The second, and perhaps next several steps along that path, must on the other hand, must be taken by you, the physicians. You are, by nature, doers and decision makers. Delegating is not always easy for you and empowerment is oftentimes even a more difficult stretch.

Even communication is often troublesome when you begin to understand that what is needed is far beyond calling your manager in for a dressing down when the schedule is messed up. Effective team leadership begins with honest and open communication between team members. The best manager/administrator in the world will not be successful if you do not communicate to them what is important to you about your practice, what your personal goals and values are and yes, believe it or not, what your fears and frustrations may be. That is how effective teams eliminate or at least minimize "rabbit chasing" time and stay focused on the big picture. At the same time, we non-physician members of the team need always to be mindful of whose practice it is. Part of our role in the eommunication process is to significantly shorten the learning curve for you, our physicians, regarding the multitude of practice management issues we face

every day so that you can actively participate in the management of your practice without having to do so at the expense of your love of medicine, your patients, your family and even the time you need to look after yourself.

Like communication, empowerment is a two way street. Effective leadership teams empower each other to use their individual gifts and talents to do what each person does best. Our staff leaves work feeling like we have had a really great day when we know that our efforts and talents have empowered our physicians to stay focused on their patients and the pure practice of medicine. For that to happen, at the same time our physicians must be working with an attitude that they trust and empower the staff to do what we have been brought together to do. Like the marriage relationship, there are times when all of us, as empowered physicians and staff, are going to mess up and make a mistake. It is in the way that effective leadership teams handle those moments that develop long term trust and commitment on the part of physicians ends staff members alike.

Trust, communication, empowerment which is most important? Pick one! Together they make up the vital chemistry of an effective leadership team. They are like three equal columns supporting the platform on which your leadership team functions. Take any one away and the whole thing falls apart. How do you get there? I can tell you this: there are no shortcuts. You need to work at it everyday. I invite you, as a physician, to work toward seeing the non-physician leaders on your team as true business partners. When you begin to see them that way you will begin to treat them that way. That level of relationship alone will motivate them far beyond anything else you can offer. We, in turn, will almost always derive our greatest professional satisfaction from being recognized and feeling like a partner in helping you to achieve and do those things that first motivated you to go into medicine. ★

Dan Bailey, CMPE, is the Executive Director for Women's HealthCare of Dothan, P.C., a nine physician OB /GYN practice and serves as the 1998 - 99 President of the Medical Group Management Association of Alabama. If there are management issues that you would like to see addressed in this series of articles, please communicate your request to Amanda Jones,amanda@masalink.org or 1-800-239-6272.

Health for All Children

Third Edition
Edited by David M. B. Hall
New York: Oxford University Press
1996, 232 pages.

This British collaboration is the most recent update on an ongoing project studying how best to promote the "surveillance" and "promotion" of good health in children. This overview approaches the problems systematically calling for single databases, with sharing of information, while maintaining confidentiality. This is a grandly ambitious undertaking to say the least.

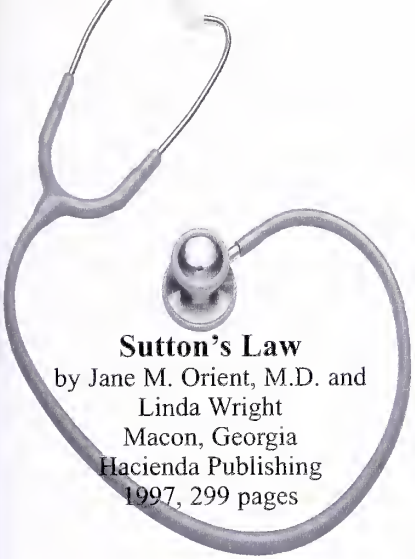
Despite its vaunting broadness, the book asks pertinent questions and offers many helpful paths to follow. One heartwarming emphasis is an opposition to the screens which are "potentially harmful" causing "unnecessary worry, referrals, and procedures." One only has to read the daily newspaper, much less leading medical journals, to learn of new findings, discoveries, better treatments, and the like. With competing claims, bolstered recently by advertisements in newspapers for prescription pharmaceuticals, who is to know what to believe. The term "antieipated decision regret" has been coined to speak to the fear of parents that if they do not agree to test, how might they feel later if something is "missed."

Primary prevention includes evaluation of hypertension and obesity, certainly major concerns in adults. The study emphasizes how much is not known about what is normality, particularly in developmental and behavioral fields. How much social engineering is possible or desirable?

This is an excellent treatise on child health care. Though written in the United Kingdom, it is quite applicable to this country as well, particularly with the two systems edging ever closer. In addition to being of interest to physicians, it would be helpful to others interested in medical care of children in general. It provides both structure and context. There are so many proposals in our state about how best to assist children. There are lists of experts a mile long. The notion of raising formal testing levels for high schools and therefore decreasing high school graduation rates always strikes me as especially vexing.

The collection of useful data in a continually updated fashion is of crucial importance in setting medical policy. This effort sets out useful paradigms which we in our state might emulate in some modified form. ★

Reviewed by David W. Hodo, M.D.
Book Editor



Sutton's Law
by Jane M. Orient, M.D. and Linda Wright
Macon, Georgia
Hacienda Publishing
1997, 299 pages

I found this book rather difficult. *Sutton's Law is* not an enjoyable book, although it is a novel penned by a physician. I immediately thought of Michael Crichton or Robin Cook as I began reading the mystery. Sadly, I was disappointed.

The writing is choppy and dull. It takes some time to get involved in the plot --probably because the author delivers her story in small bites, never giving the reader enough to digest. Briefly, the novel discusses a managed care system which has been used by corrupt physicians for their own purposes. Unfortunately, their purposes include killing patients using too many resources, unlawfully billing for services and denying needed care. Ultimately, the heroine in the novel, an intern, discovers the plot and is almost killed herself only to have the plot exposed at the last minute and the day is saved.

Sutton's Law leaves no cliché unturned. All physicians are seen as cynical, uncaring and profit-driven except for our intrepid heroine and a handful of still-idealistic interns. At the last minute, her cause saves the soul of a flinty old attending who has become jaded with medicine, and he rediscovers some idealism. Residents, attendings and patients are all droids in a giant system which reduces everything to algorithms. The head of the emergency services is a drug addict. There are few surprises.

Beyond wading through the author's prose, I guess the most difficult part of reading *Sutton 's Law* was the cynicism of physicians. Doctors are primarily concerned with making their "numbers" look good, have very little concern with individual patients and have little personal integrity. Beyond these characterizations, no one in *Sutton 's Law* ever seems to really enjoy what they are doing --there are few human characteristics to the medical staff. Rather, they are described as constantly staring into a computer monitor for a constant stream of criteria and statistical data. Even worse, no one seems concerned that they are becoming numbed and disengaged.

My question is whether this Orwellian vision is the public view of medicine (how anachronistic, I should write health care) or whether it is the way physicians are beginning to see themselves. If the public sees their physicians as robots who only carry out the dictates of third-party directors, then the future of medicine is pretty grim. One salient point was the domination of information processing in this managed care system

Reviewed by Chris Randolph, M.D.

Sutton *(continued)*

--the jump for independent humans to servants of the machine is not very far. And the public, seeing this transformation, no longer sees the physician as an authority, but as a technician who is subservient to the same overarching protocol which manages the patient. As both physician and patient see themselves as components of this larger system with progressively less autonomy, the relationship deteriorates from a sacred trust to an interaction between two cogs in a machine.

The sadder view is that physicians see themselves as jaded. Dr. Orient must have some concerns about this latter view. If the view is that the practices of medicine are changing but we can modify and maintain some integrity, then there is hope. If, however, we see current challenges as insurmountable, then we become cynical and feel all we do is meaningless. Unfortunately, the impression I get when talking to colleagues is that this latter view is gaining momentum. Many of our members feel helpless or bitter, and find little joy in the practice of medicine. Under such circumstances, patient care suffers and the profession suffers.

Overall, I found *Sutton 's Law* a rather gloomy novel. It may appeal to the lay reader, but as a physician I found it rather difficult to complete.★

INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper. Manuscripts may be mailed, faxed or e-mailed to the address below. (E-mail is preferred method.) Authority for approval of all contributions rests with the Editor. *MASA Review* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

Style: The first page should list title, the author(s), degrees and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month - day of month if weekly - and year. References should be numbered consecutively in order in which they appear in the text. *The Stylebook/Editorial Manual*, published by the AMA, is the general reference for questions of style.

Length of Articles: Articles should not exceed 10 printed pages.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be elear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

MASA Review
Attn: Amanda Jones
P.O. Box 1900
Montgomery, AL 36102-1900
1-800-239-6272 phone
1-334-269-5200 fax
amanda@masalink.org

President *(continued from page 2)*

I must interject, at this point, that I could not have done all this without the support, patience and love of my wife, Carol, and my son, Jeb. I must beg their indulgence for an even busier year ahead.

When I look at these past presidents I am overwhelmed, humbled and inspired. They have been truly great captains of the MASA ship.

Let me tell you about this ship. It is really made up of many "ships." They are: ownership, stewardship, membership, relationship, leadership, and partnership.

Let's take ownership. You are the owners of MASA, and as such you have the right, indeed the responsibility, to tell us what you want MASA to do for you and your patients. MASA is striving harder than ever to give you value for your investment and we have made great strides. We have changed our annual session to a summertime resort location to be more inclusive. We have continued our strong legislative involvement in issues, both intrusive and beneficial to our practices. We have improved our communications in the *Alabama MD*, the new *MASA Review*, The Leadership Letter, and through our improved web site for instant access to information and email capability. We have strengthened the Council of Medical Service and the Third Party Task Force to help you deal with managed care, Medicare, Medicaid, and other intrusions into your practice. We have continued to provide quality CME to you and your staffs. We have sponsored our first Leadership Conference, which was well attended and highly successful. As owners you need to be using these assets.

The second "ship" is stewardship. As owners you must also be stewards. You must be a good landlord. Because involvement in organized medicine advances the common good for your patients' benefit. After all, that is why you are practicing medicine, isn't it? If your patients benefit, you benefit. There is nothing more satisfying, more sacred, more rewarding than contributing to your patients' well being.

As stewards of medicine, we advance the profession, not just the individual. Nancy Dickey, M.D., AMA president says, "We must form a collective that bends and shapes the changing system into one that is consistent with the professionalism, the collegiality, the ethical foundation, and the commitment to our patients." As stewards we must use that collective voice.

The third MASA "ship" is membership. This will continue to be a top priority. We have added the UAB staff to our rolls this year, through the hard work of Pam Varner, M.D. and others, and hope to add the University of South Alabama staff in the near future. We have identified our membership demographics and found that the largest segment of nonmembers is young physicians and especially young female physicians. Many of them have a different paradigm than the more established doctors and much more likely to be employed by management groups and hospitals, where membership in orga-

(continued on page 42)

President *(continued)*

nized medicine is de-emphasized. Our work is clearly cut out for us. I challenge each of you in this audience to recruit two members, allowing us to meet our goal of 400 additional members this year.

More important is retention of existing members... members who are active, who will represent us well with the public, with their patients, with their medical staffs and their county, state, and national societies... members who will speak out for their patients' interests and those of their societies.

The fourth "ship" is relationship. The doctor patient relationship is essential to the success of medicine. Our code of ethics is built around this relationship... such things as providing competent service, compassion, respect for human dignity and patients' rights, honesty, continued study and application of our knowledge, freedom of choice, patient confidentiality.

Above all, we must see to it that our patients' rights are protected from those who have only a financial interest in their well being. We hope you will help us pass federal legislation giving patients these rights in managed care so you may maintain that doctor patient relationship.

The theme for this years' annual session is Alternatives 98. You have heard Wendy Arthur speak on alternative medicine. Studies show that Amerieans made 425 million visits to alternative providers in 1990, more visits than they made to primary care physicians. The main reason for this was not dissatisfaction with their doctors, but that alternative medicine was more in keeping with their wellness and holistic philosophy. Physicians need more information about alternative medicine, wellness and preventive medicine in order to provide better service to our patients and to build those relationships. My goal is to provide this information and to seek third party funding for physicians who are providing evidence based prevention, wellness, and alternative care. Wendy has agreed to help us with this. I also hope to partner with the Alabama Department of Public Health in its Healthy People 2000 project.

The other relationship we have is with our fellow physieians and with organized medicine. We intend to continue to foster closer working relationships with specialties to reduce inter-specialty friction and find areas common to each where medicine as a whole benefits... to be the mother ship and a resource for the specialty societies. Our Inter-specialty Council we have recently initiated is a good first step.

Now we look at leadership. MASA is the leading force for the medical profession in Alabama. Jack Welch, the CEO of GE said, "...the world of the 90's and beyond will belong to passionate, driven leaders...people who not only have an enormous amount of energy... but who can energize those whom they lead." We must have the passion and drive. Burt Taylor provided it in the Tort Reform movement. Craig Christopher provided it in the Patient Protection movement.

You must provide it in your local

communities, working with civic organizations, charities, and in your churches. Isolating yourselves in your medical practices will not work. You are very busy, but you must take the time to foster your social relationships and keep your compass pointed to "true north" in your organizations. You must provide energized leadership through MASA in affairs that affect the practice of medicine and your patients.

Listen to what Laura Pulfer, a newspaper columnist, said to our profession in an NPR Morning Edition broadcast:

"Here's what I'd like to do. I would put all the doctors in the country in a big drafty auditorium. They'd be wearing paper gowns, equally drafty. Here's what I'd say to them: 'Isn't it about time you rescue medicine from the questionable mercies of business and politics? You were the smartest kids in the class, so why are you letting everybody else tell you how to do your job? You people who became doctors were the brains, the bookworms, the eagle scouts, the merit scholars. You were the ones whose homework the rest of us copied because you had the answers. You are the people with the magnificent arrogance to put your hand around the pulsing human heart. You were the voices bright enough to give us the bad news.

'So what's the problem? Are you scared of a bunch of bean counters? You whipped their butts on the SAT's. Now they're making the medical decisions in consultation with you. Consultation? Why aren't you running the show? Are you really prepared to become just another employee? Why do you allow insurance companies and managed care to demand that young couples leave the car running when they enter the maternity ward? Where have you been? On some extended golf vacation? Is it the money? Is it us? Are you tired of taking care of us and our untidy illnesses? I beg of you, get back in the game. When I get sick, I would still like to know there is a doctor in charge, not some MBA.

'Okay, now get out of those ridiculous paper gowns and start acting like doctors again.' "

That's some kind of indictment. It's a wake up call for us who have not yet been fully exposed to managed care to show our leadership. This year more than ever, partnering with the AMA, we will be working on health insurance reform, both private and government, state and federal, taking back control from the MBA's and the bean counters. Leadership is mandatory at this critical time.

And now, the most important ship...partnership. All the ideals, vision and intent will be for naught without commitment to partnership. Our partnership must include educated awareness, political involvement, and establishing communication with those most affected by the issues we face...your patients. You have the opportunity, indeed the responsibility, to shape the future of medicine. Your partners in MASA provide you the collective voice. As John Donne said, "no man is an island" has never been truer than in medicine today.

(continued on page 44)

President *(continued)*

So these are the "ships" of MASA. A strong fleet, sailing on treacherous seas. Our crew is courageous, intelligent, hard working, and independent. Our passengers are safely in their berths, unaware of the perils confronting steel ships floating over water. Our crew is beginning to sense the danger. The hazards of fraud and abuse, E & M coding, a government who is determined to fund Medicare on the backs of doctors, political and business systems that want to run medicine and intervene in the doctor patient relationship.

Our captains and crews must negotiate our directions in the storms which are brewing, something we can only do collectively, cooperatively, with a unified vision. We must stay the helm; otherwise, we will sail blindly into storms, mine fields, and other hazards.

Our captains have not been passive, but have worked hard to steer around the iceberg of third party intervention, but more is required to navigate ships. We must have the full cooperation and effort of our crew and this is where you come in. Doctors can no longer be passive and let others tell us how to manage our business, our practices, our patients and our relationships with each other. Without proper navigation, education, communication, and hard work our ships will surely sink.

So there you have it. Great ships: ownership, stewardship, membership, relationship, leadership, and partnership. Your elected leadership will work diligently to make our greater ship the finest to set sail. We encourage you to get on board.

Executive *(continued from page 3)*

this issue which addresses many of these challenges. It turned out to be an excellent gumbo (I'm from Louisiana, so please excuse this analogy.)

Last, but certainly not least, I want to thank Dr. Curry, William Lightfoot, M.D., chairman of the Board, and the rest of the Board members, for the support and guidance they have given me during my first year on board. Taking over from Lon Conner was a daunting challenge. But Lon left MASA on solid ground, strong from a membership perspective and strong financially. I was able to come in, take the baton from him and work with the Board and the excellent staff Lon had accumulated to address the future needs of the MASA membership.

Thanks again to all who have made my first year with MASA such a rewarding experience. I look forward to working with the Board, the Councils, county and specialty societies and staff to continue advocating for Alabama physicians and their patients. ★

Curry *(continued from page 5)*

with our staff - old and new.

So, a year later, after significant internal changes and ubiquitous challenges, how is the Medical Association of the State of Alabama? I can tell you with firm conviction and compelling evidence that the state of this association is strong. Besides the strategic plan itself, we have had a remarkably successful transition in senior staff. Cary Kuhlmann has built upon the successes of Lon Conner as Executive Director just as we had hoped he would. Membership development, recruiting and retaining members, has new energy and new successes. We are about to deliberate how best to incorporate academic and other governmental physicians into the membership and programs of the association. Internally, we now have a functioning Long-Range Planning Committee that keeps an eye on matters that escape routine monthly Board oversight. The Council on Medical Service is newly invigorated and is serving as a resource and idea center for the association. Relations with the business community, once strained by our patient protection legislative initiative, are improving. Leadership development has been warmly received, with enthusiastic conferences and our best attended Washington D.C. trip ever. Communication with members is even better, with redesigned publications and better use of our website. We are redesigning the annual session, with a different time, different locations, and different formats. No wonder I'm glad to be passing the torch to Joel Pittard - this has been a lot of work!

This association is stronger than a year ago, not so much because of new or reorganized personnel, or because of its officers, or even because of the great programs I have mentioned. If these have contributed to our gains, it has been only marginally. MASA is stronger because our members are showing increased interest and activity in the affairs of our association. In the final analysis, this is the only valid reason to say a medical association is stronger, because a medical association is its members. It is you, those members, who are the foundation of MASA, the centerpiece of organized medicine in Alabama.

While we recognize the essential roles of specialty organizations, here is where we determine the future of organized medicine in this state - in this House of Delegates, through the actions of this Board, through the initiatives of these Councils and committees.

While many of us are active and effective politically, here is where the values of Hippocratic medicine and the beliefs of the physicians of Alabama are translated into effective political action, through the policies of this House and the decisions of this Board, implemented through a legal and governmental affairs staff that are second to none.

While many of us speak clearly about the health issues before us, here is where the full range of public concerns about health can be addressed: about costs and management of a health care system in which high

(continued on page 46)

Curry *(continued)*

technology medicine collides daily with global pressures to economize; about patients who need protection in such an environment; about small business people trying to compete; about threats to the integrity of our practices; about the needs of rural and inner-city Alabama; about minority groups who have been left behind the advancing economic surge; about migrant groups with limited access to health care; about the mentally and physically disabled citizens of our state; about young people tempted by alcohol, tobacco, illicit drugs, and early sex; about an infant mortality rate that while falling, is still far too high; about the complex relationships between health issues and our challenged educational system.

While we acknowledge the importance of our own practices, medical staffs, IPA's, and provider panels, here is where we determine the positions of the medical profession concerning the laws, regulations, and other public policies that define the boundaries of what is and what is not the sound and ethical practice of medicine, of what is and what is not fair to patients, of what is and what is not a fair balance of cost, quality, and access in health care. It is here, in MASA, that we can and should attend to "the relationships with our patients and our colleagues that...really matter": supporting one another as diverse specialists, taking political action, addressing health issues in public forums, refining the roles and ethics of the practice of medicine.

We can count on it being a struggle. In every organization, there is a natural tension between different approaches to both process and substance. Here in our own association, we are asking: Should we have central eontrol by the Board or more participation by members? Is departmentalization better, or should we move to team building? Should we stay behind the scenes or seek more public exposure? Then there are the questions about what we do, and what the priorities should be.

As we and our successors struggle with these questions, are there truly guiding principles for us to follow? I believe there are, and they are found in our ancient heritage as physicians. Are there ways to identify what principles apply, or which ones are threatened at a given moment? While there is no infallible solution, I believe we find the perspective we need by looking at the larger pieture. It is like finding the pattern of a mosaic, or seeing our planet from the dimension of outer space.

The perspective we need for the future of our association is to be found in the struggles of the profession it serves. While the history of medicine has been marked by profound change, the changes of this twentieth century have been more rapid and more fundamental than any other. The result is a struggle for the soul of this ancient profession.

Traditional medicine was atomized, personalized, face-to-face with patients, with tiny support structures. Twenty-first century medicine is corporatized, detached from patients,

surrounded by massively complex support teams and institutions - from the new phenomenon of academic medical research and education centers to global pharmaceutical firms, hospital conglomerates, insurance giants, governmental bureaucracies, and every conceivable technician and advisor.

All of this self-supporting corporatized structure demands more and more from society: health expenditures in this country are at 15% of gross domestic product, with 4.5 million employees and 5% of the labor force, only one in seventeen of whom is a physician. Small wonder that a hospital executive explained his switch from the fast food industry by saying that hospitals had more growth potential than Kentucky Fried Chicken! In the 1850's, Claude Bernard could finance his research from his wife's dowry; Huntingdon was a little-known New York country doctor. We know how medical research is financed now, and what it can produce. It is a system filled with ironies, of great progress but great costs, elegant technology but erratic aceess, solid accomplishments but escalating demands.

It is a struggle for the soul of medicine. It can be distilled to two dilemmas: the price of progress and the disenchantment that comes from unmet inflated expectations. While Medicare and Medicaid strap federal and state government budgets, and our business colleagues demand restraint on their health costs to remain globally competitive, American infant mortality figures remain higher than most of the industrialized world, and new plagues threaten our short-lived security. Just as we can see hope in managing or even preventing AIDS, quirky viruses such as Ebola emerge, and madmen threaten germ warfare by employing such old enemies as the anthrax bacillus.

To address such unwelcome dilemmas, we must move beyond the high-tech, quick-fix mentality that the medical industrialists and marketeers offer. It is not a matter of abandoning the technology; it is a matter of making it our tool instead of our master. It is not a matter of ignoring the need for rational financing of a complex enterprise; it is a matter of putting the patient back at the center of the system. "Patient protection" as a program is itself a sad irony, a reminder that we have to scramble to protect the patient from the very system that ostensibly exists for his or her benefit.

In his book The Greatest Benefit to Mankind, Roy Porter throws at you and me both an indictment and a challenge. Listen to a little of what he says: "The irony is that the healthier western society becomes, the more medicine it craves - indeed, it regards maximum access as a right and duty. Especially in free market America, immense pressures are created - by the medical profession, by medi-business, the media, by the high-pressure advertising, of pharmaceutical companies, and dutiful (or susceptible) individuals - to expand the diagnosis of treatable illnesses. Scares are created. People are bamboozled into lab tests, often of dubi-

(continued on page 48)

ous reliability. Thanks to diagnostic creep or leap, ever more disorders are revealed. Extensive and expensive treatments are then urged, and the physician who chooses not to treat may expose himself to malpractice accusations. Anxieties and interventions spiral upwards like a space-shot off course.

"The root of the trouble is structural. It is endemic to a system in which an expanding medical establishment, faced with a healthier population, is driven to medicalizing normal events like menopause, converting risks into diseases, and treating trivial complaints with fancy procedures. Doctors and 'consumers' are becoming locked within a fantasy that everyone has something wrong with them, everyone and everything can be cured."

Porter concludes: "...medicine's finest hour is the dawn of its dilemmas...medicine will have to redefine its limits even as it extends its capacities." I think Porter gives us too much credit. We will not "redefine" our limits. We will recognize them and admit them. We do it all the time, of course, when we talk with patients and families, but it is one of the hardest things we do. We don't like admitting our limits, and they don't like hearing about them.

But it is not just a matter of admitting our limits and our patients' mortality. If we concentrate only on the truism that the mortality rate is ultimately 100%, we will miss a lot of opportunities to help a lot of people, and meanwhile the medical industrialists and marketeers will assume total control. It is a matter of putting the patient back where he belongs, at the center of this system, not at the margins, in control of his or her decision-making, not an afterthought in the process.

Whether it is in the organization of our clinic visits, the hospital, and the telephone, or the daunting task of financing one seventh of our economy, the patient must be at the center. The patient must be at the center as we approach whatever may be the issue of the month or the crisis of the moment. At this moment, it is financing health care, and the unintended consequences of trying to reform that financing, which create most of the crises. The latest fad, of course, is managed care. Putting the patient at the center of managed care takes us to such arcane topics as "medical savings accounts," "defined contribution plans," "E&M codes," and "patient protection." Next year, and the year after, the vocabulary will change. That is about all we can know with certainty. What will not change is our obligation to continue the struggle at the center of medicine, the struggle to keep the patient there at the center.

That is as much of a standard as our profession has ever needed, and it is enough for our association. It is a struggle to do it consistently, both as individual physicians and as an association, but it is not that hard to remember. After all, the people we serve remind us of it every day.

Thank you for your attention, thank you for your support in the past year, and thank you for the privilege of serving as your president. ★

Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

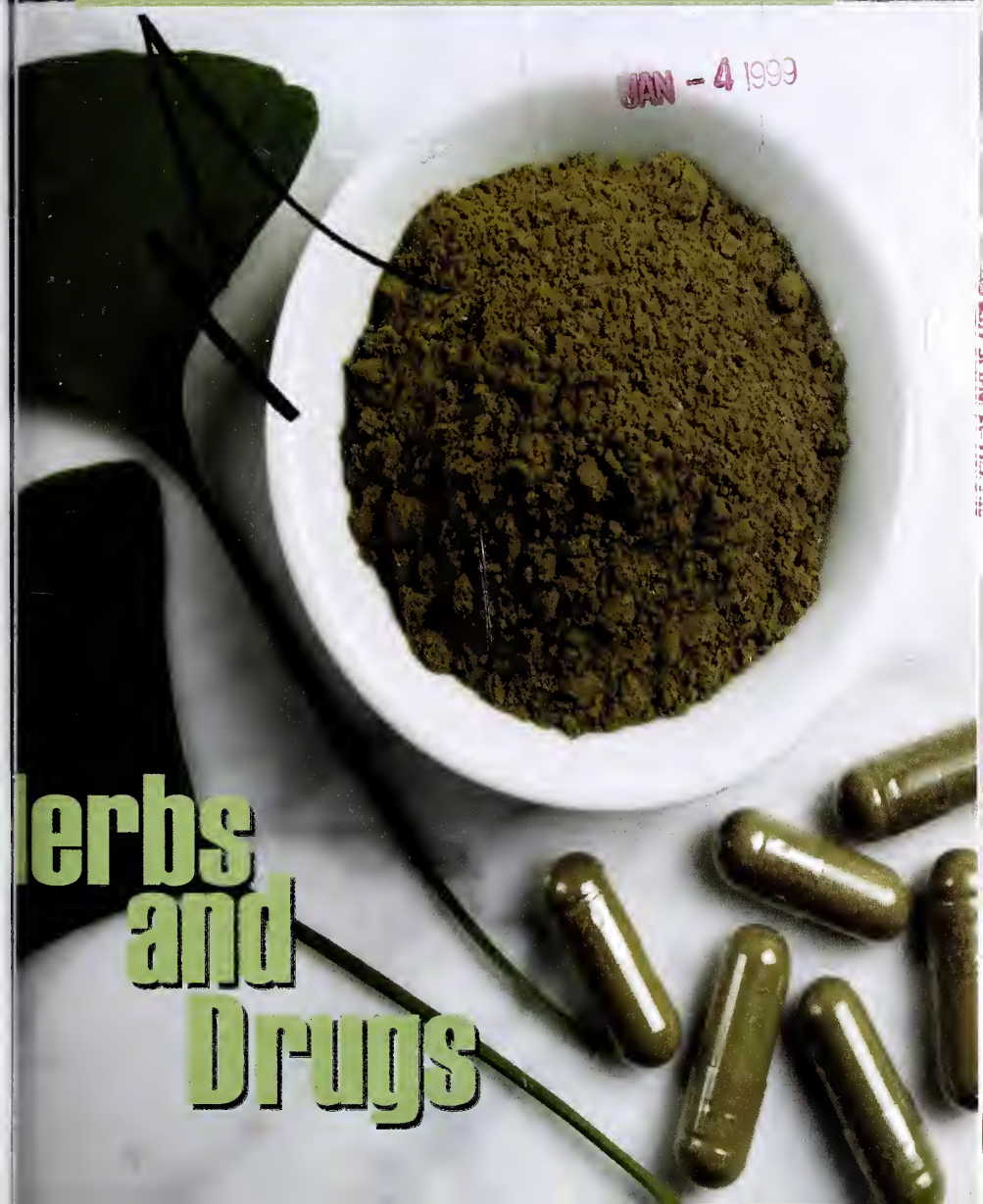
POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800 282 6242 / 205 877 4400

Volume 2 Number 3, Winter 1999

MASA REVIEW

Incorporating Alabama Medicine,
The Journal of the Medical Association of the State of Alabama

JAN - 4 1999



Herbs and Drugs

Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800.282.6242/205.877.44

MASA REVIEW

Incorporating **Alabama Medicine**, *The Journal of the Medical Association of the State of Alabama*

Volume 2, Number 3 **Winter 1998**

USPS 2844720 ISSN 0738-4947

Editor William A. Curry, MD
Managing Editor Amanda Jones
Book Review Editor David W. Hodo, MD

OFFICE OF PUBLICATION: PO Box 1900, Montgomery, Alabama 36102-1900. Subscription Prices: member, $15; non-member $30 per year. Periodicals postage paid at Montgomery, Alabama and at additional offices. Published quarterly by the Medical Association of the State of Alabama at 19 South Jackson Street, Montgomery, Alabama 36102.

POSTMASTER: Send address changes to MASA REVIEW, P.O. Box 1900, Montgomery, AL 36102-1900.

Established 1931, published by and for the Medical Assoeiation of the State of Alabama for open and responsible discussion of matters relevant to medicine and other fields of interest to physicians. Conclusions and opinions expressed herein are those of the individual authors. No portion of this publication may be reproduced in any form, including electronic, without written consent. Publishers reserve the right to reject any advertising with or without explanation.

Copyright 1998 by the Medical Association of the State of Alabama.

IN THIS ISSUE

6
Patient Care, Herbs and Drugs
Wendy Arthur, MD

14
Howard Lamar Holley, MD
William H. Dodson, MD

22
The Disruptive Physician II: The Role of Personality Disorders
Charles V. Ford, MD & Gerald L. Summer, MD

DEPARTMENTS

President's Message	2
Executive Director	3
Editor's Column	4
MASA Services	35
Technology Talk	36
Calendar of Events	40
Malpractice Column	42
Book Review	44
Author's Instructions	51

Continuing the Fight For Patients' Rights

"The healthier Western Society becomes, the more medicine it craves — indeed, it regards maximum access as a right and duty," states Roy Porter in his book, The Greatest Benefit to Mankind, a Medical History of Humanity.

Faced with this tenet, employers, government, health plans, and physicians are seeking a solution. Each entity has its own goals — health plans, employers, and government want to decrease access to care, physicians to maximize access. Health plans, employers, and government want to micromanage health care to decrease costs, and for government sometimes the motives appear to be to maintain full employment for a burgeoning bureaucracy. Physicians, on the other hand, want what is best for their patients and expect to receive a reasonable fee for their services.

Given these competing forces, how can we satisfy all parties and still provide our patients with the finest healthcare?

Two years ago, with Craig Christopher as MASA president, we sought a solution to one of the perceived problems through the Alabama Legislature. Known as "The Patient Protection Act," it attempted to right some of the egregious problems, such as denials of care, we were beginning to see coming from managed care. Unfortunately, due to opposition from the business community, the bill never saw the light of day. It was obvious to us at the time, that to seek passage the following year would also prove fruitless. It was time to seek other strategies. We decided to work directly with business, insurers, and health plans on non-legislative solutions and await Federal legislation, for which the public clamored, to help achieve some balance.

So, what has happened in each arena?

MASA leadership, Third Party Task Force, and staff have activated our first strategy. We have begun discussions with leadership of Alabama Association of Health Plans, Blue Cross, and Alabama Health Care Council to discuss our goals and seek common ground. We recognize that each party (physicians, patients, and health plans) has responsibilities and we have delineated these in the areas of access to and continuity of care, communications, financial considera-

Continued on page 46

—Joel C. Pittard, M.D.

Invest Now!

It's a new year. The stock market has been up and down. Interest rates are low. Where do you put your money?

How about investing in your profession?

That's right. It's dues renewal time for your MASA, county, and AMA membership dues as well as your contributions to your political action committees, ALAPAC and AMPAC.

First, thanks to all of you who have already re-invested. Dues notices have been out about three months now and the response has been excellent. Glad to see so many of you recognize what your professional associations have been accomplishing as we advocate on your behalf.

Second, for those of you who have not sent in your investments, you are asked to have your office manager or bookkeeper dig it out of that stack of bills and write that check now!

Third, for those of you who have just made partial investments, you are encouraged to rethink your decision about less than full participation.

Why? I'm a firm believer that joining MASA, your county, the AMA and contributing to the political action committees should be considered part of your office overhead, just like your electric bill. It should be automatic and complete.

Sure, you always can find some reason not to join. I'll even help you with the most common excuses which are cost, don't like what MASA or the AMA did about such-and-such an issue, don't know what they do for me, and, but I support all my specialty and sub-specialty societies. Let me debunk those arguments.

First, cost. When you package the dues to which I've referred, you're talking about $1,000 to $1,320 depending on your county society dues. **This is only $2.77 to $3.67 a day!** (Yes, we work a lot of weekends.)

Second, with the complexity and broad range of issues affecting health care delivery, there will be times that your medical associations don't act exactly the way you like. That's part of the democratic process, however, and many times decisions are made by consensus. What you need to consider, though, is how often are we on target and what's our batting average.

Third, your elected leadership

Continued on page 50

—Cary Kuhlmann, Executive Director

A NOTE FROM THE EDITOR

Weighing the Alternatives

Just when I think I can't handle another cephalosporin, a new NSAID, or a different mechanism of platelet inhibition, along comes a totally unexpected category of unfamiliarity: my grandmother's herbal remedies. The latest wave of magazine and television health ads are not just suggestions that unconventional therapy can make life longer, joints more supple, and sex more wonderful. The truly informed are those who know just which brand of gingko biloba is best for preventing cerebral insufficiency[1], or which form of echinacea stops cold viruses in their tracks. (It's the one with the ladybug mascot.)

All this falls under the general heading of "complementary and alternative medicine," a concept now sufficiently institutionalized as the Office of Alternative Medicine (OAM) at the National Institutes of Health (NIH) that it has its very own abbreviation: CAM.[2] The OAM was founded in 1992 in response to obvious public interest; by 1990, one in three Americans were seeing an alternative health care practitioner each year, 400 million visits' worth, more than to all conventional primary care physicians. They incurred costs of $13 billion, paying $10 billion from their own pockets.[3]

The interest is not limited to the general public. More than 50% of conventional U.S. physicians use or refer their patients for such treatment.[4] In Europe, CAM is even more pervasive. For example, some of the most frequently written prescriptions by German physicians are for herbal products.[5]

So when MASA included a presentation at the last annual session on CAM, was it just being CAMpy? I hope it was more than that. Despite an office at NIH, the research base on CAM is poor. While practices such as acupuncture and meditation may carry relatively low risk of direct harm, botanical preparations are chemically powerful enough to result in both direct toxicity and serious herb-drug interactions. Even the lower-risk approaches may be associated with serious delays in diagnosis and treatment.

As result of these risks, physicians and patients need to be aware of what is out there. Just as importantly, physicians and patients need to talk

Continued on page 48

—William A. Curry, M.D., F.A.C.P.

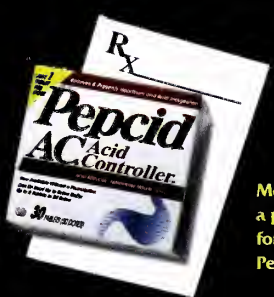
Pepcid AC Acid Controller.
ACID REDUCER / FAMOTIDINE TABLETS 10 mg

Covered by Alabama Medicaid

ACID INDEPENDENCE

FREEDOM FROM THE HIGH COST OF HEARTBURN

• **Pepcid AC®**	**$0.28 per dose[1]**
• Ranitidine 150 mg	$1.48 per dose[1]
• Prilosec® * 20 mg	$3.59 per dose[1]



Medicaid requires a prescription for coverage of Pepcid AC 10 mg

Prilosec® (omeprazole) is a registered trademark of Astra Merck

1. Sources: IRI November 1997, *Red Book Update* November 1997, IMS America September 1997

Johnson & Johnson-MERCK Consumer Pharmaceuticals Co. 1998

® Registered Trademark of Merck & Co., Inc.

JMAR 0397 2.25

Patient C

Herbs and D

INTRODUCTION

According to the trade publication Nutritional Business Journal, Americans spend $3.6 billion on herbal remedies and are projected to spend $5.9 billion by 2000. New and perhaps cheaper treatment options are a mixed blessing with concerns regarding side-effects, drug interactions and purity of preparations.[1]

PURPOSE

Landmark Healthcare released a study in January 1998 revealing that the two most popular complementary and alternative medicine (CAM) approaches were chiropractic and herbal medicine. [2] The purpose of this article is to:

1) further educate allopathic physicians in a very popular and ever more confusing arena of phytotherapy (herbal medicine)

2) to begin introduction of the most popular herbs with a review of the safety of more popular herbs as well as known drug/herbal interactions; and

3) list reference books/databases and web sites to assist in patient care. [3]

re,

gs

By Wendy Arthur, MD

TOP FIVE HERBS IN SALES IN 1997 ACCORDING TO THE NUTRITION BUSINESS JOURNAL, SAN DIEGO:

1) St. John's Wort
2) Echinacea
3) Ginseng
4) Gingko biloba
5) Garlic

* *

SAFE TO UNSAFE HERBS [4]

Safe

Bilberry

Chamomile

Echinacea (avoid if patient has autoimmune disease, AIDs or TB)

Feverfew

Garlic

Ginger

Gingko Biloba (interacts with ASA and Warfarin)

Ginseng (avoid caffeine, if patient has HTN, pregnant or lactating and may decrease efficacy of warfarin and antihypertensives)

Hawthorn (used in CHF, stable angina, MI recovery and may potentiate digoxin)

Milk Thistle

Saw Palmetto (used for BPH and may cause H/A, GI upset and muscle pain; also may lower PSA levels)

St. John's Wort (used as antidepressant, avoid tyramine foods and SSRI; also phototoxic)

Valerian (sedative and sleep aid, binding weakly to benzodiazepine receptors with paradoxical stimulant effect in 5-10% individuals; avoid barbiturates, benzodiazepines, and opium)

Vitex

Moderately Unsafe
Bearberry
Black and Blue Cohosh
Boneset
Comfrey
Juniper
Licorice
Lobelia
Wormwood

Unsafe

Chaparral: hepatotoxic (FDA logged several cases); used for pain control and cancer prevention

Ephedra: absolute contraindications include HTN; DM; Glaucoma

Hydrangea: leaves contain cyanide

Poke Root: lethal in children; used in breast cancer and RA

Sassafras: contains safrole, a carcinogen that may damage the liver

Yohimbe: used with phenylpropanolamine; may lead to CVA

* *

POSSIBLE HERBAL/DRUG INTERACTIONS

The foundation of preventing herbal/drug interactions is obtaining a complete history from the patient in an open-minded manner acknowledging to them that this field of study is in its infancy. Encouraging the patient to add one herb at a time rather than combination products will simplify sorting out possible interactions/or reactions. Delivery of prescription medications may be delayed by those which contain large amounts of mucilage (e.g. aloe gel, flaxseed, marshmellow root, slippery elm bark) Delayed delivery may be avoided through patient education.

The following contains precautions to assist in avoiding possible herbal/drug interactions in these six areas:

1) Heart medications
2) Anti-coagulants
3) Diabetes medications
4) MAO inhibitors
5) Sedatives
6) Delayed delivery

Heart Medications

Ephedra: (ma huang) natural bronchial dilator and decongestant which when mixed with CV meds causes arrhythmias, HTN

Herbal laxatives: prolonged use can cause hypokalemia

Goldenseal: found in natural cold/flu preparations and constricts blood vessels which might effect BP

Guarana: adrenal hormone booster with caffeine as active ingredient

Kola nut: active ingredient caffeine

Licorice: (glycyrrhiza) found in digestive aids, cough syrups, Danish candies can cause hypokalemia

Siberian ginseng: related chemically to digoxin, so may increase blood levels

Anti-coagulants

Recommend patient avoid these herbs if taking Coumadin, ASA:

Bromelain: derived from pineapple; used to alleviate O.A.

Feverfew: a migraine remedy

Garlic: natural antibiotic also having anti-coagulant properties

Ginko Biloba: inhibits platelet clumping

Ginseng: believed to impede Coumadin's actions

Diabetic Medications

Guar gum: found in low or non-fat products; prevents absorption of Glucophage

Glucomannan: found in some weight loss products; may lower glucose levels thus changing insulin and/or oral diabetic medication requirements

Medicinal Plants Which Lower Blood Sugar: [5]

Bitter Melon (Momordica charantia)
Cornsilk (Zea mays)
Dandelion (Taraxacum officinale)
Prickly Pear (Opuntia spp.)

MAO Inhibitors

Brewer's yeast: B supplement elevates BP
St. John's Wort: theoretical MAO inhibitor properties
Yhimbe: elevates BP
Ephedra: elevates BP

Sedatives

Kava Kava: widely used in Germany; has muscle relaxant, anti-convulsant and analgesic properties; appears to have less cognitive impairment than benzodiazepines and no tolerance in one 25 week trial; in-vitro studies show herb to interact with GABA and NMDA receptors

Valerian: few clinieal trials in literature; however, no side effects reported and doesn't appear to interact with other psychotropics or alcohol.

Jerry Cott, PhD, states Valerian, Kava, Chamomile and hops have in common a high level of GABA-binding activity. [6]

* * * * * * * * * * * * * * *

WHERE TO GET MORE INFORMATION

"Alternative Health Care: New Promise, New Pitfalls," a brochure from the National Consumers League aimed at consumers. Available for $1 from: National Consumers League, 1701 K Street N.W., Suite 1200, Washington, D.C. 20006

The Honest Herbal, Varro E. Tyler, PhD, SeD (Pharmaceutical Products Press, 1993) America's foremost expert on herbs and safe to unsafe herbs plant-derived medicine.

http://cpmcnet.columbia.edu/dept/rosenthal/AM_Information.html
www.landmarkheatlhcare.com or email info@landmarkhealthcare.com (Study released in January 1998 Landmark Report on Public Perception of Alternative Care)

http://www.healthyideas.com (excellent resource for handouts to patients; sponsored by Prevention magazine)

http:www.pharminfo.com (Pharm resource including articles, an alphabetical database and other information)

www.homeopathic.com (Homeopathic educational services) ★

* *

References

1. American Medical News, August 17, 1998.

2. Landmark Report on Public Perceptions of Alternative Care. www.Landmark/healthcare.com or info@landmark.heatlhcare.com

3. http://cpmcnet.columbia.edu/dept/rosenthal/AM_Information.html (Also available in print Wooten JC: Directory of databases for research into alternative and complementary medicine. J Altern Complement Med 1997; 3(2):179-190. 1-800-654-3237.

4. Clincial Rounds, Family Practice News, July 15, 1998, pg. 30a

5. The Honest Herbal, Varro E. Tyle, PhD., ScD, Pharmaceutical Products Press, 1993

6. Family Practice News. July15, 1998, pg. 30a

TALKING TO PATIENTS ABOUT ALTERNATIVE MEDICINE

- Do your homework. Learn about complementary/alternative medicine paying special attention to safety issues.

- Understand the patients motivation. Support his/her goal of feeling healthier and preventing disease.

- Keep an open mind. Ask nonjudgemental questions about their use of unconventional therapies. By resisting the temptation to condemn they will reveal more to you.

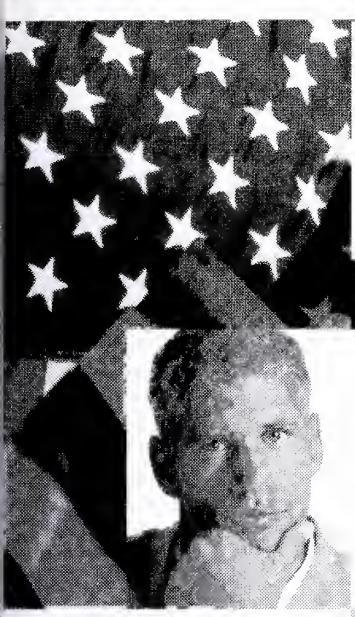
- Discuss the risks. Be honest about scientific evidence. If a patient's practice poses no danger, don't discourage it.

- Encourage careful consumerism. Patients should avoid providers that order expensive tests at the initial visit, promise immediate relief, or boast of fantastic cures.

- Compromise. If a patient insists on using therapy that you consider unsafe or ineffective, propose a time limit after which the patient may try conventional therapy.

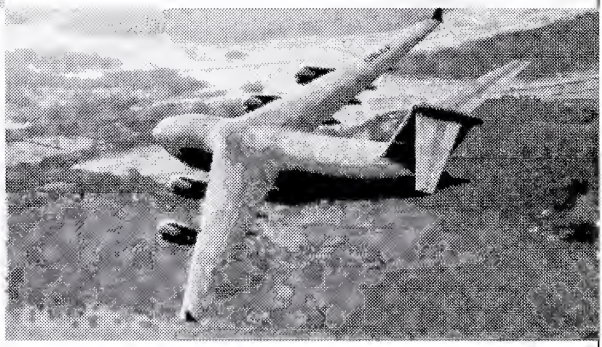
- Follow-up. Regularly ask how their therapy is going.

(Sports Medicine Vol. 26, No. 6. June 98)



PHYSICIANS

TAKE YOUR MEDICAL CAREER ABOVE & BEYOND



If you're a physician looking for a change of pace above and beyond the ordinary, consider becoming a commissioned officer/physician with the Air Force Reserve. As in civilian life, Air Force Reserve physicians provide critical and preventive care and vital clinical services.

However, as a Reservist, your medical expertise can take you around the globe and into real-world scenarios that will take healing above & beyond. Air Force Reserve physician/officers hold a position of special trust and responsibility. Combined with training opportunities in areas such as Global Medicine and Combat Casualty Care, paid CME activities, you will find yourself among an elite group of health care providers. All it takes is one weekend a month and two weeks per year. Feel the pride of doing something above and beyond for your country
while adding a new dimension to your medical career.

Call 1-800-257-1212.

Or visit our web site at www.afreserve.com

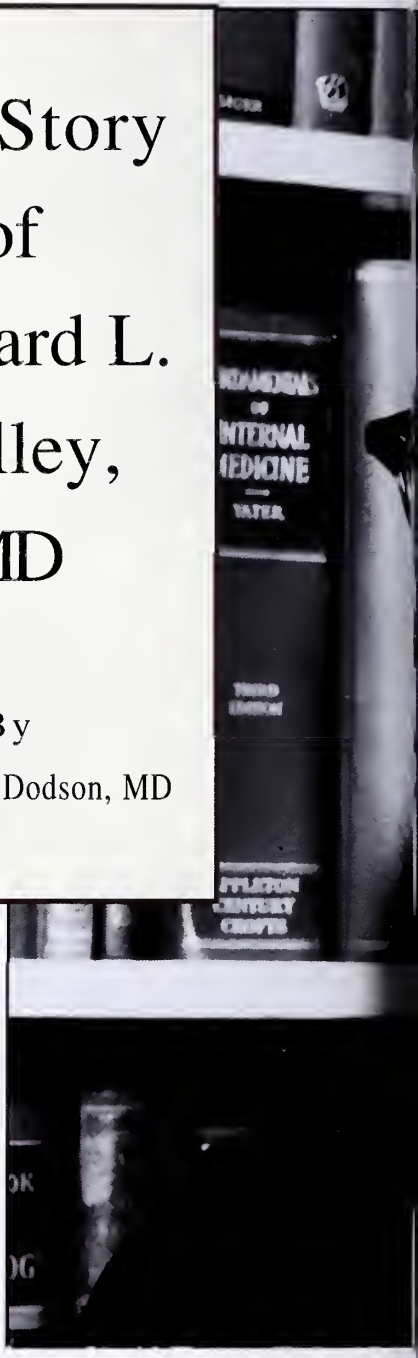
AIR FORCE RESERVE
ABOVE & BEYOND

APN 25-801-0007

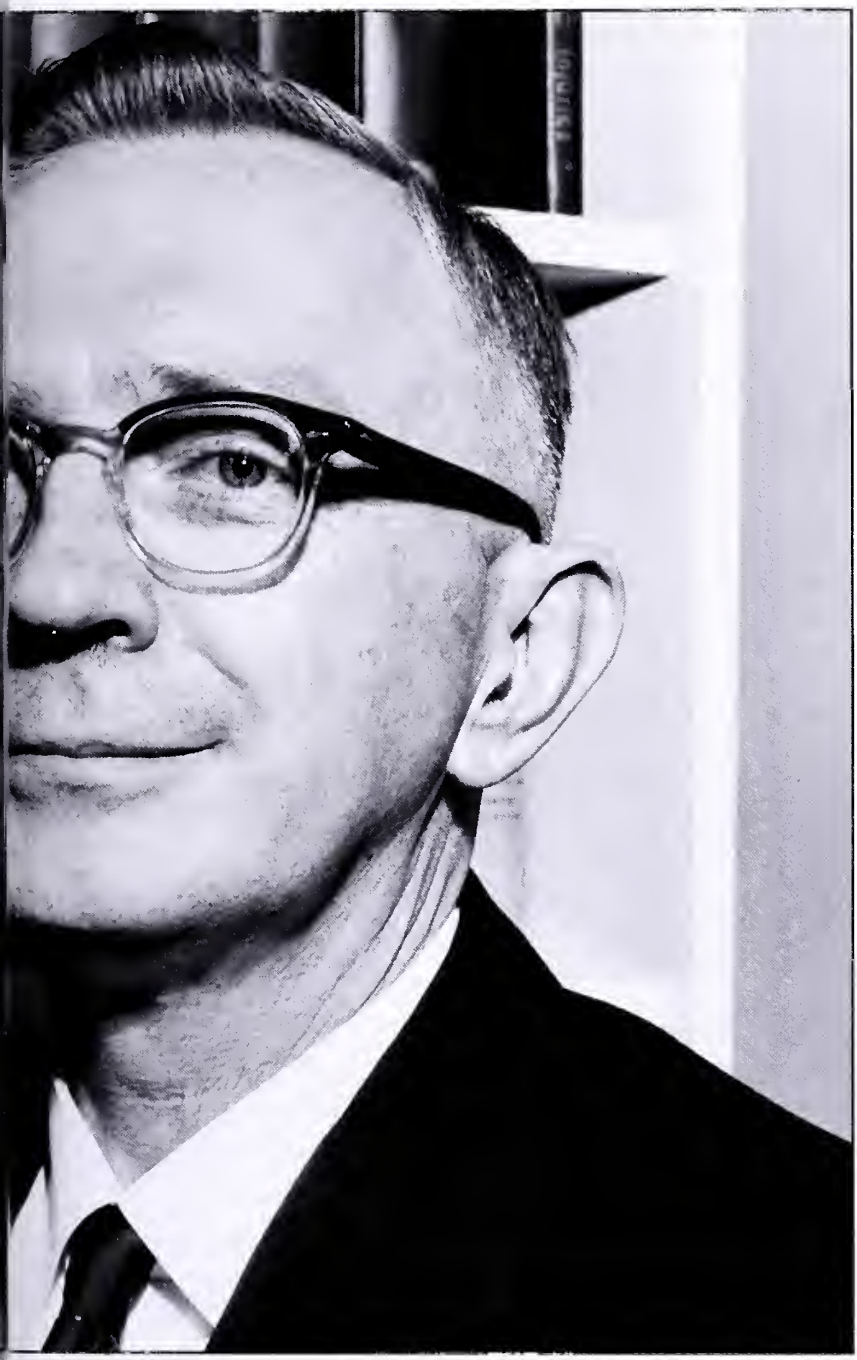
The Story of Howard L. Holley, MD

By

William H. Dodson, MD



He was a man of many talents: research scientist, caring physician, medical historian, devoted husband and father and cherished friend of many. Following his service in the U.S. Public Health Service and Coast Guard in World War II, he came to what was then Jefferson-Hillman Hospital as one of the initial two residents in Internal Medicine in 1945. From that time until his retirement in 1985, he had an uncommon view of the development of that embryonic center into something that exceeded all expectations: The University of Alabama at Birmingham Medical Center. At the time of his retirement it was estimated that Dr. Holley had taught half of the practicing physicians in Alabama. Along the way he received a multitude of honors including Alpha Omega Alpha, Distinguished Faculty Lecturer at UAB, Distin-



guished Internist Award for Alabama, Distinguished Service Award of the Medical Association of the State of Alabama, mastership from American College of Physicians, and Distinguished Service Award from Southern Medical Association in 1980.

Born July 14, 1914 in Marion, Alabama, he grew up on a 208-acre cotton farm in Perry County, Alabama, several miles from the village of Hamburg. (Figure 1) Although his parents worked the fields with the help of several black families who lived on the farm, Lamar, as he was known locally, was somewhat limited in his farm work by migraine headaches and frequent nosebleeds. Mrs. Mary Ward Brown, a childhood friend and noted short-story writer, describes him as a kind and thougtful, thin, redheaded boy, who did not particularly stand out at that point. He did, however, excel in mathematics and science in school. His sister, Ruby Holley, recalls his walking the winding, dusty road to wait for the rudimentary school bus with flapping canvas sides to take him to high school ten miles away in Marion. There he thrived on ehemistry experiments.

Figure 1 - Howard L. Holley at age three.

Figure 2 - Warren Alton Holley and Lula Fretwell Holley, parents of Howard L. Holley

His father, Warren Alton Holley, was tall and handsome and had the same quiet charm that Lamar was to later enjoy. (Figure 2) Lula Fretwell Holley, his mother, was a beloved leader in the community and pianist at the Hamburg Methodist Church for many years. Lamar's kindness, patienee, and attention to people were gifts from "Miss Lula." The Holley farm bordered the Cahaba River and Lamar and his sisters, Mildred and Ruby, enjoyed racing to the swimming hole. Their first home burned in 1920 while the family was attending church in Hamburg, according to Mrs. Annie Ford Wheeler, a close childhood friend and Hamburg historian. With assistance from their neighbors, they built the house that

remains in the family at the present time. (Figure 3)

Times were hard in Perry County during the depression years and particularly on cotton farms following the appearance of the boll weevil. Little money was available for further education, but young Lamar desperately wanted to go to college and then to medical school. Fortunately, Dr. Guy Lipscomb, dean of the chemistry department at the University of South Carolina, in Columbia, owned a farm adjoining the Holley farm. In the summers he would often come down to supervise work on his farm and occasionally would spend a night in the Holley home. He came to know and admire Lamar, but also realized that he did not even have bus fare to South Carolina. When Lamar asked him for help in getting into the University of South Carolina, Dr. Lipscomb took him back to Columbia with him, helped him get enrolled, paid his tuition, and helped him get small jobs to pay other expenses.[1] Often Lamar also "happened" to come by the Lipscomb home on campus at midday meal time and, of course, was invited in. During the following four years he won friends and admiration for his wonderful spirit and determination against great odds, graduating in 1935.

Following college, still short of funds, he taught school for one year at St. David's Academy in Society Hill, South Carolina. Then he studied for a summer term at the University of Heidelberg on scholarship and enjoyed Paris along the way.

Again, with the help of his friend, Dr. Lipscomb, he was able to gain entrance to the Medical College of South Carolina in Charleston. As a freshman he applied for a job at Porter Military Academy as house

Figure 3 - Holley farm near Hamburg, Alabama

doctor, which was usually reserved for senior medical students. After having been turned down, he recalled walking down a lonely line of trees out of the military school. But the commandant, struck by the young student, called him back and gave him the job — plus room and board — and he lived at the military school throughout medical school. During medical school summers he worked with Dr. W.W. Harper in Selma. Lamar never forgot what Dr. Lipscomb had done for him in financial help and in encouragement and friendship. That debt would be repaid later to the benefit of many.

Internship was at the U.S. Marine Hospital in Norfolk, Virginia but further training was interrupted by World War II. Having failed to pass the Navy physical exam, he entered the U.S. Public Health Service and served for the next three years, often attached to the U.S. Coast Guard (figure 4). Late in the war he was stationed on a destroyer escort in the North Atlantic but came home to Philadelphia on D-day. One benefit of his service time was meeting pretty Martha Holcomb Gross, who was a student at Duke University while he was stationed in Durham (figure 5). She was also to experience his "coming around regularly at mealtime."

Shortly before discharge from the U.S. Public Health Service, he noticed pain and swelling of one knee and then the other one. Thus began the malady with which he was to deal so courageously for the rest of his life and which was to affect his choice of medical career.

Figure 4 - Howard L. Holley in Coast Guard in World War II.

In 1945 he was invited to become one of the first two residents in Internal Medicine at Jefferson-Hillman Hospital by Dr. James S. McLester, who was to become quite influential in the life of Dr. Holley. Dr. McLester was Chairman of the Department of Internal Medicine, as well as a widely known authority in metabolism and nutrition, and had published a textbook entitled Nutrition And Diet In Health And Disease which had gone through six editions. He had won many awards in medicine as well as serving as the 88th president of the Ameri-

can Medical Society, but had always stated that his greatest satisfaction came from the esteem in which he was held by his former students and residents. This philosophy was to have great impact on young Dr. Holley.

On September 7, 1946, he convinced Martha Holcomb Gross to forgo her college education at Duke University and to become his bride. She was to become invaluable as a sustainer and friend.

He joined the faculty as instructor in the Department of Internal Medicine in 1947. Dr. McLester continued to encourage him and because of his influence, Dr. Holley's early publications dealt with abnormalities of sodium and potassium metabolism. In 1953 he became director of the University of Alabama Tumor Clinic and served in this capacity until 1966.

At this point in his career, joint inflammation was intermittent for him, but was of increasing concern and he began to focus on treatment of arthritic conditions. In 1951 he published an article entitled "The Use of ACTH and Cortisone in Certain Disease States." Many more publications dealing with rheumatological disorders were to follow. His appointment by Dr. Tinsley Harrison as director of the Division of Clinical Immunology and Rheumatology came in 1955, and he remained in this capacity until 1970, becoming a pioneer in the field. He was among the first at U.A.B. Medical Center to realize the importance of basic research in clinical medicine and received one of the very first National Institutes of Health research grants. From 1961 to 1965

Figure 5 - Martha Holcomb Holley and Howard L. Holley.

he served as a member of Arthritis Training Grants Study Committee of the N.I.H. and rapidly assembled an outstanding research team in his young rheumatology department.

With the addition of Dr. Gene Ball and Dr. J. Claude Bennett to the group in the summer of 1965, it was recognized as one of the outstanding rheumatology departments in the country. Dr. Bennett, as a resident in Medicine at U.A.B., had previously worked with Dr. Holley on several projects regarding systemic and discoid lupus erythematosus, and they had kept in touch during his subsequent training. Dr. Holley's encouragement and support had much to do with Dr. Bennett's returning to U.A.B.

An important aspect of Dr. Holley's career was the development of the rheumatology service at Spain Rehabilitation Center, one of the few such centers in the country. He felt the need of a multidisciplinary center involving physical therapy, special-

ized nursing, and social service with the physician playing a leadership role, and the concept proved to be quite effective. Dr. Holley also began the first juvenile arthritis program in the nation with the Alabama Crippled Children's Clinic in Birmingham.

His fascination with the history of medicine began early and with intensity. From 1957 to 1983 he had 34 publications regarding past figures in medicine. He particularly admired Sir William Osler and published Osler's letters to his friend Ned Milburn in A Continual Remembrance in 1968. Dr. Holley commented that "Osler's rare gift of continuing friendship to all he chanced to meet has been unsurpassed." He was to become a charter member of the Osler Society. His wonderful ability to bring physicians of the past to life is recalled by medical students and medical residents fortunate enough to have attended his medical history sessions in the old Reynolds Library. At a time when his rheumatoid arthritis had become severely debilitating, he struggled to complete the definitive book A History of Medicine in Alabama.

The title of his Distinguished Faculty Lecture in 1969, "And Gladly Teach," accurately described his philosophy on the subject. A sly sense of humor along with an enjoyment of debate made his attending rounds provocative and occasionally tense, as his methods were not always gentle. In an unpublished essay "Au revoir" he wrote, "In my life of professional teaching, I have never

THE ARMY RESERVE OFFERS UNIQUE AND REWARDING EXPERIENCES.

As a medical officer in the Army Reserve you will be offered a variety of challenges and rewards. You will also have a unique array of advantages that will add a new dimension to your civilian career, such as:

- special training programs
- advanced casualty care
- advanced trauma life support
- flight medicine
- continuing medical education programs and conferences
- physician networking
- attractive retirement benefits
- change of pace

It could be to your advantage to find out how well the Army Reserve will treat you for a small amount of your time. An Army Reserve Health Care Recruiter can tell you more. Call:

CALL COLLECT
770-960-7641
205-930-9719

ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.®
www.goarmy.com

endeavored to make young men more efficient; I have tried to make them more interesting. If one is interested, one is usually interesting. The business of the teacher is not to supply information, it is to raise intellectual thirst. I like to hang intellectual pictures on the walls of the mind, I like to make it possible for a man to live with himself, so that he will not be bored with himself. For my own part, I attempt life every day as if this were the first day I had ever seen and the last I were going to see." Perhaps his greatest gift was the ability to understand the emotions of young physicians and to inspire in such a way that they were usually unaware of it.

Dr. Holley truly possessed the genius of friendship. Many a young physician received his soft and humble guidance without intrusion in a time of crisis as well as his support, both emotional and financial. Often he would receive calls from long distances and after many years from "his boys" seeking assistance of some type, and he did not disappoint them. Dr. Archibald Rutledge, poet laureate of South Carolina, was a long time friend with whom Dr. Holley enjoyed visiting at his ancestral home in South Carolina. Their regular correspondence from 1954 to 1971 was an interesting one. Although friendship came quite naturally for him, one wonders about the influence of Dr. Lipscomb and Dr. Osler.

Family life was important and enjoyable for him whether trying to solve everyday problems or enjoying family outings on the Panama City beaches. The Holcomb farm in nearby Trussville, Alabama was the site of many gatherings and his struggle in shoulder-high pond water with a large bass later held aloft in triumph is still remembered.

Rheumatoid arthritis became a severe problem for him in 1960 and in 1969 he was further slowed by a fracture of the right hip. A fall in 1974 resulted in fractures of bones in both legs rendering him unable to continue seeing patients. Congestive heart failure became an increasing problem in 1986 along with recurrent infections. Throughout all this he remained remarkably upbeat and uncomplaining until his final day - March 17, 1988. ★

Acknowledgements

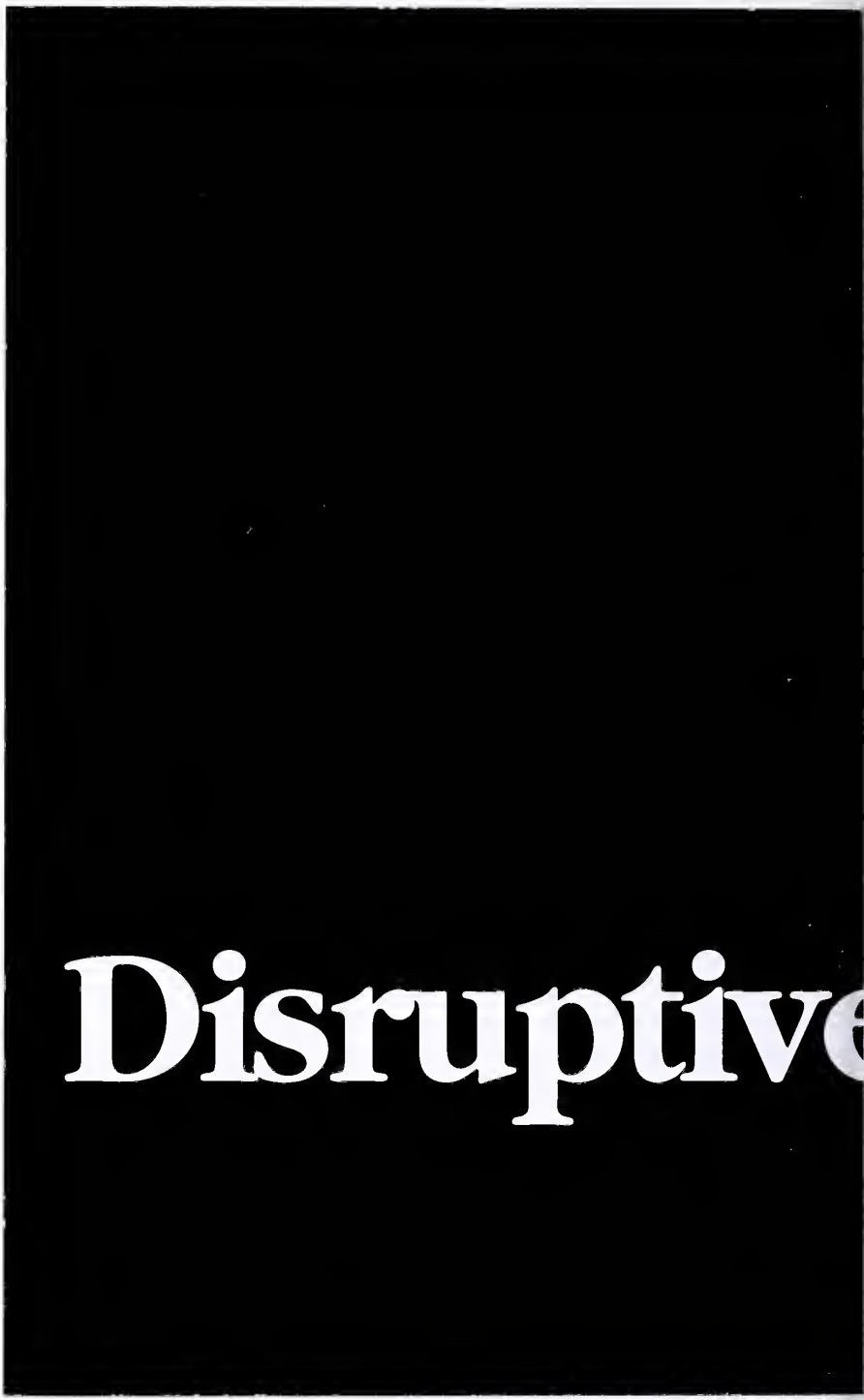
I am extremely grateful to Mrs. Martha Holley for allowing me to review the papers of Dr. Howard L. Holley and for providing family photographs and especially for her encouragement. I also am appreciative of the kindness and assistance of Mrs. Annie Ford Wheeler, Dr. Glynn P. Wheeler, Mrs. Mary Ward Brown and Mrs. Adelyn Lipscomb Richardson.

Credits for Figures

Figure 4 - Courtesy of UAB Archives

References

Personal correspondence from Mrs. Adelyn Lipscomb Richardson daughter of Dr. Guy Lipscomb.


Disruptive

An increasing number of complaints regarding unacceptable physician behaviors are made to hospital staff offices, medical licensure boards, and other official bodies. [1, 2, 3] These complaints that allege rude or disruptive behaviors,

inappropriate sexual comments, or demands for special

The Disruptive Physician II: The Role of Personality Disorders

Gerald L. Summer, M.D., Medical Director
Physicians Recovery Network
Medical Association of the State of Alabama
Montgomery, AL

Charles V. Ford, M.D., Professor and Director
University of Alabama at Birmingham
Neuropsychiatry Clinic
Department of Psychiatry and Behavioral Neurobiology
Birmingham, AL

Reprinted from the Federation Bulletin:
The Journal of Medical Licensure and Discipline

treatment reflect current societal attitudes that reject abusive behaviors, irrespective of the status of the perpetrator. These behaviors are not new. In the past, physicians were often excused on the basis of such rationalization as high stress, over work, or sleep deprivation.

In a previous manuscript published originally in the Federation Bulletin and reprinted in the MASA Review, the various factors that may result in complaints of physicians' behavior were described, along with an emphasis on the importance of Axis I psychiatric diagnoses and substance abuse.[4] In this communication, personality traits that may predispose physicians to disruptive behaviors, and those selective factors which have motivated persons with certain characteristics to seek a career in medicine will be explored. Personality traits, however, are by no means separate from substance abuse and/or psychiatric problems. In fact, the presence of a personality disorder is a risk factor for substance abuse, depression, and other psychiatric disorders.

This report is based on retrospective anecdotal experiences rather than a systematic investigation. During the past 35 years, Charles V. Ford, M.D., has evaluated and/or treated more than 400 physicians, including research subjects in residency training programs. [5,6] Gerald L. Summer, M.D., has investigated complaints made to the Alabama Physicians' Recovery Network program and has interviewed more than 500 physicians regarding these complaints.

This type of report risks bias due to the selective factors regarding which physicians were referred. Only physicians who requested psychiatric treatment or who were referred because of complaints concerning their behavior were studied. The presence of any theoretical bias also can produce selective memories. Furthermore, findings may represent characteristics of physicians who

trained at an earlier time. Present day medical students differ demographically from earlier cohorts. Now, a greater percentage of women and ethnic minorities is present. Thus, these findings must not be extrapolated to fit all or even most physicians. Within the constraints of this caveat, these findings are useful in providing heuristic models for evaluation, treatment, and future research.

Motivations to enter a profession are a complex mixture of both conscious and unconscious factors. [7] One such important factor is how members of the profession are viewed by the general public and the esteem bestowed upon them.

The Idealized Physician

Medicine is perhaps unique in that physicians have a rich, historical heritage and are frequent subjects of dramatic interest in books, movies, and television. The physician plays a mysterious role in the rights of passage of birth and death and is often believed to have special knowledge and powers. The physician also is often idealized by society for humanistic qualities. To quote Wilson and Larson, "The physician, then, is seen by society as a heroic Godlike person - a superintelligent, self-sacrificing, moral, trustworthy, perfect, reliable individual who has leadership abilities that are sacrificially presented to society for its use." [8]

Conscious Motivations to Enter Medicine

Consciously-stated motivations to enter medicine are sometimes cynically interpreted as rationalizations. They should not be discounted. All behavior is not unconsciously determined. Among reasons frequently offered by applicants to medical schools are an interest in and a desire to help others, an interest in science, fascination with the processes of disease, and, by no means least, a desire to make a good income. Prior to the inereased control of physicians by governmental agencies, corporate medicine, and the managed care companies, medicine was also viewed as highly desirable because of the degree of professional autonomy that it offered. Many physicians have stated to the authors that a major motivation to apply to medical school was "I wanted to be my own boss."

Unconscious Motivations to Enter Medicine

Many authors have described several recurrent themes that have motivated persons to seek a career in medicine. Among these are fears of disease and death, and the use of medical education as a counterphobic mechanism to deny and compensate for these fears. [9, 10, 11] Medicine can also be a way of obtaining an idealized identity for someone whose personal identity is insecure or incomplete. For example, one of our physician patients reported that he instantly decided to go to medical school when, while walking on Michigan Avenue in Chicago, he saw a Navy doctor wearing his dress blue uniform. This young man believed that if he, too, could wear

such an impressive uniform, he would feel masculine, in control of himself, and admired by others. At the time of his impulsive decision, the future Navy doctor had, following a tumultuous childhood and college years, just been fired from a teaching job because of incompetence and inability to control the behavior of his students.

Another physician, seen in consultation because of severe chronic depression, reported that he had decided to become a doctor during his childhood. At a time when beset by feelings of worthlessness, he had perceived doctors to be admirable persons in control of their lives. Many physician patients reported childhoods characterized by multiple moves, poverty, or physician abuse. They indicated a desire to enter a profession in which they would feel powerful and "never hungry again."

Sexual problems are remarkably common among physicians. It has been hypothesized that medicine, with its involvement and knowledge of mysterious aspects of all body functions, may offer solutions to issues of sexual conflicts or feelings of genital inadequacy. [12]

It appears clear that for at least some persons, the profession of medicine offered promise to resolve underlying psychological conflicts involving disease, death, sexuality, feelings of inadequacy, powerlessness, a need for autonomy, and poor self-esteem.

Psychiatric Disorders in Medical Students and House Officers

Previous, albeit somewhat dated, studies have shown that medical students, interns, and residents have a significantly higher incidence of psychiatric problems than would be expected by chance. [13, 14] One report found that 35 percent of medical students studied had a positive family history of psychiatric illness, mostly affective disorders or alcoholism. [14] Problems reflecting significant anxiety concerning some aspect of sexuality[12] or characteristics of obsessive-compulsive personality[15, 16] were particularly prevalent. These reports are evidence that persons entering medicine bring their problems with them, rather than implicating medicine as the primary cause of the problems.

Conclusion

It appears clear that for at least some persons, the profession of medicine offered promise to resolve underlying psychological conflicts involving disease, death, sexuality, feelings of inadequacy, powerlessness, a need for autonomy, and poor self-esteem. Such issues constitute an underlying matrix

of personality characteristics and also are risk factors for Axis I psychiatric disorders.

CHARACTERISTICS OF PERSONALITY DISORDERS

"A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment."[17] The Diagnostic and Statistical Manual, Fourth Edition (DSM-IV), of the American Psychiatric Association[17] lists 10 specific personality disorders and a diagnosis for "not otherwise specified," which includes mixed features. The personality disorders are grouped into three clusters. Cluster A includes schizoid, paranoid, and schizotypal types. Cluster B includes antisocial, histrionic, narcissistic, and borderline types. Cluster C includes avoidant, dependent and obsessive-compulsive types. Phenomenologic features often overlap from one personality disorder to another, particularly within the same cluster.

Current thinking about the etiology of personality characteristics includes genetic factors, parenting styles, and the influence of cultural/subcultural factors. Personality traits are often easily identifiable in childhood and become prominent or "fixed" by late adolescence. Although there has traditionally been a separation between Axis II (e.g., personality disorders) and Axis I disorders (e.g., social phobia), increasing recognition shows considerable phenomenologic overlap. In some situations, the differences may only be points on a continuum (e.g., schizotypal personality disorder and schizophrenia).[18]

PERSONALITY DISORDERS IN PHYSICIANS

All DSM-IV personality disorders in physicians were observed, including schizotypal, which is the most bizarre. Of particular interest were the differences between those physicians who sought treatment on their own initiative and those for whom consultation was mandated.

Self-referred Physicians

The primary reason that physicians seek care on their own is for complaints of depression and/or anxiety. Their personality traits/disorders tend to fall into the passive, avoidant, obsessive-compulsive, and, sometimes, narcissistic categories. The discomfort of these physicians is much more likely to be internal and ego-dystonic. Problems with interpersonal relationships are common, but less likely to be of a disruptive nature. This is illustrated by the following vignette:

> Dr. A, a 42-year-old surgical subspecialist, sought treatment because of symptoms of anxiety. He noted that his life was ruled by both his controlling wife and his office manager. He was seemingly unaware that the office manager was an employee of his

rather than his supervisor. He wryly noted that he had been unable for years to get his hospital to buy new operating room equipment, but that a new addition to the surgical staff had achieved this goal in short order by stating loudly he would not operate at the hospital again until the equipment had been obtained. This example illustrates how fear of confrontation can be maladaptive, and how this fear may reflect an intrapsychic confusion of appropriate assertiveness and disruptive aggressive behavior.

Mandated Consultations

Physicians for whom psychiatric consultation was mandated tended to follow a different pattern. Diagnoses, commonly observed included substance abuse, manic episodes, and personality disorders of the Cluster B category (antisocial, borderline, narcissistic, and histrionic types). Complaints of disruptive behavior had led to an investigation which, in turn, involved psychiatric evaluation. These disruptive behaviors most commonly involved temper tantrums ("narcissistic rage"), verbal and/or physician assaults, verbal abuse, entitled demands for specific treatment, uninvited sexual advances, insensitive, rude or inappropriate social behavior, and false accusations against others.

By the time of psychiatric consultation, these referred physicians had generally become more calm and had sufficiently rationalized behaviors to present themselves in a favorable light. Problems were not internalized; quite the contrary! These individuals described themselves as victims of incompetent administrators, greedy competitive colleagues, or just misunderstandings. Disruptive behaviors that were minimized (frequently in striking contrast to investigation reports) were largely reported as reactions, and justifiable, to the misbehaviors of others. For this reason, supplemental psychological testing was regarded to be an essential component of most evaluations. The Minnesota Multiphasic Personality Inventory (MMPI) was a very useful adjuvant to assessment, particularly because the validity scales reflect the degree of defensiveness toward the evaluation.

Some personality disorders were seen in the more pure form, e.g., narcissistic, obsessive-compulsive, paranoid, and borderline. But the most commonly seen personality disorders were those with mixed features, e.g. narcissistic, obsessive-compulsive, borderline, paranoid, or antisocial features in various eombinations. For men, the most common diagnoses were mixed personality disorder with narcissistic and obsessive-compulsive features, narcissistic personality disorder with narcissistic and paranoid features. For women, the most common personality disorder was mixed personality disorder with borderline and narcissistic features.

Not surprisingly, the overwhelming majority of these physicians who required psychiatric evaluation were

not interested in psychiatric treatment or, at best, gave psychotherapy lip service, attended a few sessions, and then drifted away.

The following vignettes illustrate typical situations that involved disruption behaviors secondary to personality disorders:

> Dr. B, a 38-year-old internist, was referred for evaluation after complaints were made to his hospital medical staff regarding the aftermath of a patient care incident. Dr. B was unavailable by pager when one of his patients suddenly developed pulmonary edema. Another physician assumed care, transferred the patient to the intensive care unit, and instituted emergency treatment. When Dr. B rounded later that day, the patient was no longer en extremis. Dr. B was furious, transferred the patient out of the ICU, screamed at the nurses, verbally attacked the "good Samaritan" physician, and, when asked to explain his earlier unavailability, raged at the medical chief-of-staff with raw profanity.
>
> Developmental history indicated Dr. B was raised in an unaffectionate working class family where misbehavior was strictly punished and the work ethic emphasized. College and medical school were financially supported by part-time work and loans. He had largely avoided interpersonal contact and married a woman with similar personality characteristics.
>
> On examination, Dr. B denied or minimized all psychological symptoms. The MMPI suggested findings consistent with a self-reliant, but constricted individual who was overly concerned about privacy, out of touch with personal feelings, and intolerant of any suggestions of problems being beyond his capability to personally solve. Marked discrepancies were present between the Weiner-Harmon Subtle/Obvious Subseales in that the subtle scales for psychopathic deviant and paranoia were significantly elevated.
>
> Dr. B exhibited no evidence of an Axis I diagnosis and was diagnosed as a Personality Disorder, Mixed Type, with narcissistic and paranoid features.

> Dr. C, a 43-year-old, married emergency room physieian was referred for psychiatric consultation by the Alabama Physicians' Recovery Network following numerous complaints from nursing staff and patients alleging that he shouted rudely and in a humiliating manner at patients, nurses, and clerical staff. There had been at least two previous investigations of his behavior, but one hospital had dropped charges after he filed a retaliatory lawsuit. The physician described the complaints as misunderstandings resulting from his attempts

to motivate incompetent staff to correctly fulfill their responsibilities.

Dr. C's personal history indicated that poverty and negleet from his parents marked his childhood. He had worked his way through college and medical school. He described himself as a workaholic, demanding, perfectionist, and expecting no less from those who worked with him.

Psychological testing (MMPI) was consistent with a person who was likely to be suspicious, guarded, argumentative, hostile, and hypersensitive to the opinions of others, and who believed that he had received a "raw deal in life."

The physician was described by the psychiatrist's clerical staff to be irritable and contemptuous toward them, but while in the consultation office, he was noted to be ingratiating and glib in his rationalizations of his behavior.

Dr. C exhibited no evidence of an Axis I disorder, and the psychiatric diagnosis was Mixed Personality Disorder with paranoid, narcissistic, and obsessive-compulsive features.

Dr. D, a 48-year-old surgeon, was referred by the Alabama PRN for evaluation after he assaulted and injured an intoxicated patient. He explained that no formal charges had been brought against him because it was determined that he had acted in self-defense. A large number of complaints had, over the years, been lodged against Dr. D because of his angry verbal attacks on nurses and his habit of throwing instruments in the operating room. Informal information suggested that because he was the hospital's largest "producer," there had been reluctance to take formal action against him.

Formal history revealed that poverty and a "bad-tempered" mother marked his childhood. As a child and adolescent he was involved in many fights. His contacts with the legal system were limited to numerous speeding tickets. Dr. D described himself as a workaholic, "outspoken as hell," and as being very proud of his financial empire.

Other than annoyance toward his psychiatric examination, which he believed to be a waste of time, Dr. D had no findings on mental status examination. The MMPI clinical scales were within normal limits, but the Wiener Harmon Subtle-Obvious subscales showed significant increases in the subtle hysteria, psychopathic deviate, and paranoia subscales. Theses findings suggested more disturbance in the area of personality disorder than was overtly obvious.

In follow-up, Dr. D continued to have conflicts with patients and nursing staff and

was ultimately dismissed from his hospital staff for cause.

Most evaluations for disruptive behavior complaints involve male physicians. There are, however, exceptions. The following female physician was evaluated at the request of her medical chief-of-staff because of recurrent interpersonal conflicts with colleagues. Dr. E acknowledged that she had been prescribed an antidepressant during medical school and that any time she attempted to discontinue it, she became depressed and irritable. She had taken this medication regularly for the preceding several years.

Dr. E talked openly of her contempt of other physicians who were not as dedicated as she to patient care and/or who were not as current with the medical literature. She was aware of her interpersonal problems, but seemingly unaware that other physicians, unlike herself, had a life outside the hospital.

Personal history indicated that the patient was the eldest of four children from a home disrupted by divorce when she was 12. Her mother was overtly alcoholie, and the care of the household and her younger siblings frequently fell to the patient. Dr. E's father was an intellectually brilliant, but emotionally detached man whom the patient tried to please through her academic success. She finished first in her class in high school and college and, resentfully, just missed being first in her medical school class.

Dr. E agreed to psychotherapy and, in general, kept appointments for three years until she left the geographical area. During this period, Dr. E's appearance and demeanor would alternate from being dressed in masculine-styled suits and talking about her total commitment to medicine, to wearing dresses, makeup, and fingernail polish and talking about her wishes to become a wife and mother. The patient displayed frequent emotional storms and rage attacks when she perceived herself as criticized. The technique of therapy was to focus her attention upon the feelings and needs of others and how her behavior impacted them. Despite a stormy course of psychotherapy, she made progress and was able to maintain her hospital staff privileges.

DISCUSSION

This communication does not attempt to report the frequency of personality disorders in physicians as compared to the general population. In fact, it is uncertain if any such epidemiological study exists. The importance of the interplay of personality traits (personality disorders in the more extreme presentation), however, in both the seleetion of medicine as a career and as to how such traits can cause dis-

ruptive behavior when the physician is stressed is convincing.

Persons who feel powerless, have low esteem, a poor sense of personality identity, or who feel their personal needs have been neglected may view a career in medicine as a solution to these issues. Certainly, popular views of doctors suggest that physicians have special characteristics that evoke admiration. Thus, the profession of medicine may attract people who have a defective sense of self and who have overcompensated for feelings of uniqueness, to the point of grandiosity, are often reinforced by their patients' need for a physician who is omniscient and omnipotent (the positive transference of the idealized parent). Narcissistic physicians fail to recognize that transference phenomena reflect patients' needs rather than the personal qualities of the physician. Consumed by a self-centered view of the world that fails to take into account the feelings and needs of others, the disruptive narcissistic physician demands special treatment (entitlement), is overly sensitive to criticism and threats to self-esteem, and may react with rage and attempts to place blame elsewhere.

Certain personality traits may be selective in determining the choice of medicine as a career and also predictably lead to disruptive behaviors.

Obsessive-compulsive personality traits have been frequently observed in physicians. Selective factors may be important in that those individuals who have a capacity for organization, a willingness to work hard and delay gratification, seek perfection and are conscientious, are more likely to be successful applicants to medical school. These very qualities, that in moderation are often desirable, can cause difficulties in interpersonal relationships. The obsessive-compulsive physician may be controlling, moralistic, overly demanding of perfection, inflexible, and unable to delegate tasks to others. The obsessive-compulsive physician may erupt in anger, particularly in a self-righteous manner, when others fail to live up to expectations or not do as they told. These physicians who set high standards for themselves may be intolerant of the necessities of the real world, such as the need for compromise and the acceptance of human failings. The obsessive-compulsive physician also may become depressed when there is a sense of personal failure or may attempt to project blame elsewhere. In summary, the obsessive-compulsive physician frequently is not a good team player, and interpersonal difficulties may lead to disruptive behaviors.

This report confirms observations between physicians who seek psychiatric treatment on their own

and those for whom evaluation is mandated by another party.[19] The former group is more likely to have an internalized sense of personal failings and continue their treatment, benefiting from psychiatric treatment. The latter group externalize their distress (blame others) and, as noted previously,[2] drop out of treatment when no longer in duress. Unfortunately, our experience with mandated treatment is not favorable.

Primary prevention treatment interventions are more effective than secondary/tertiary interventions when behavioral patterns have become resistant to change. Although no empirical data available validates these recommendations, increased knowledge about the psychological aspects of motivations to enter medicine, and the provision of more social support at all training levels, may help prevent the concretization of some of the disruptive behavioral patterns that have been described.

SUMMARY

Certain personality traits may be selective in determining the choice of medicine as a career and also predictably lead to disruptive behaviors. Physicians who are self-referred for psychiatric treatment tend to have depression, obsessive-compulsive, dependent, and avoidant personality characteristics. Physieians for whom psychiatric referral is mandated because of complaints of disruptive behavior tend to have obsessive-compulsive, narcissistic, and paranoid traits. This latter group is much more likely to project onto others the responsibility for their disruptive (mis)behaviors. Treatment of the latter group is difficult because of poor compliance, but in some cireumstances may be beneficial.

References

1. Crna LW. The disruptive physician. *J Amer Assoc Nurse Anesthesists*. 1995;63:377-379.

2. Donaldson LJ. Doctors with problems in an NHS work force. *BMJ*. 1994; 308:1277-82.

3. Benzer DG, Miller MM. The disruptive-abusive physician: a new look at an old problem. *Wisconsin Med J*. 1995;94:455-459.

4. Summer GL, Ford CV, Lightfoot WM. The disruptive physician I: the Alabama physicians recovery network. *Fed Bull: J Med Licens and Discip*. 1997;84:236-243.

5. Ford CV. Emotional distress in internship and residence: a questionnaire study. *Psychiatric Medicine*. 1983; 1:143-150.

6. Ford CV. Wentz DK. Internship: what is stressful? *Southern Med J*. 1986;79:595-599.

7. Ford CV. Physicians: the other half of the doctor-patient relationship. *The Somatizing Disorders: Illness as a Way of Life*.

Elseirer, New York. 1983;203-222.

8. Wilson WP, Larson DB. The physician and spouse: physician know thyself and they mate. *NCMJ*. 1981;42:106-109.

9. Abram HS Emotional aspects of heart disease: a personal narrative. *Int J Psychiatry Med*. 1978;8:255-233.

10. Golloway G. Are doctors different? Reflections on the psychodynamics of physicians. *J Fla Med Assoc*. 1981;68:281-284.

11. Menninger KA. Psychological factors in the choice of medicine as a profession. *A Psychiatrist's World: Selected Papers*. Fall BH ed. Viking Press, New York. 1959.

12. Woods SM. Sexual problems of medical students. *Medical Aspects of Human Sexuality*. 1972;6:66-85 passim.

13. Golden JS, Marchionne AM, Sil ver RJ. Fifty medical students: a comparison with normals. *J Med Educ*. 1967;42:146-152.

14. Pitts F Jr. Winokaur G, Stewart MA. Psychiatric syndromes, anxiety symptoms and responses to stress in medical students. *Am J Psychiatry*. 1961;118:333-340.

15. LiefHI, Young K, Spruill V, Lancaster R, LiefVF. A psychodynamic study of medical students and their adaptational problems: a preliminary report. *Med Educ*. 1960;35:696-704.

16. Schlageter CW, Rosenthal V. What are "normal" medical students like? *J Med Educ*. 1962;37:19-27.

17. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. American Psychiatric Press, Inc. Washington, DC. 1995;629-673.

18. Siever LS, Davis KL. A psychobiological perspective of the personality disorders. *Am J Psychiatry*. 1991;148:1647-1658.

masa services

THIRD PARTY TASK FORCE

The Third Party Task Force is a committee of MASA which consists of physician members who provide assistance to other physicians in resolving issues and disputes with insurance companies, HMOs, other third party payors, including Medicaid and Medicare, and other peer review organizations. Member physicians requiring the assistance of the Task Force should send a letter detailing the nature of the dispute and copies of relevant correspondence or medical records to MASA. *Contact: Wendell Morgan 1-800-239-6272*

PHYSICIANS RECOVERY NETWORK

The Physicians Recovery Network promotes the early identifieation, evaluation, and treatment of physicians who may be impaired as a result of mental/emotional illness, or substance abuse/dependence. A documented program of recovery is offered to enable these physicians to return to practice. The PRN staff is available to present several educational programs suitable for all audiences. *Contact: Jerry Summer, M.D., 1-800-239-6272*

COLLECTION AGENCY

One of the biggest problems for physicians is collecting fees owed to them by patients. Keeping costs down and cash flowing are critical factors in the success of any practice—fiscal soundness is a must, and physicians need an effective collection agency to assist them in recovering delinquent accounts such as I.C. Systems, Inc. *Contact: I.C. Systems, Inc. 1-800-685-0595*

GOLD MASTER CARD PROGRAM

Your MASA membership entitles you to participate in this outstanding credit card program, featuring a credit line up to $15,000, no first year annual fee and an annual fee of only $30 after the first year. *Contact: MBNA 1-800-847-7378 Ext. 400*

MAGAZINE SUBSCRIPTION PROGRAM

MASA members can take advantage of low subscription rates for a tremendous array of popular and specialty magazine, which include *TIME, The New Yorker, US. News & World Report, Vanity Fair,* and *Better Homes and Garden. Contact: Subscription Services, Inc. 1-800-289-6247*

TRAVEL AND HOTELS

MASA has made arrangements with Destinations Quest International Hotel Savings Program to enable you to enjoy savings of up to 50% off standard hotel rates and up to 25% discount on many hotel restaurants at more than 2,100 top quality hotels. *Contact: MASA 1-800-239-6272*

LONG DISTANCE TELEPHONE SERVICE

DeltaCom was chosen to offer a program to physicians because of their commitment to personalized customer service, simplicity of billing statements, as well as DeltaCom's unique ability to customize business long distance accounts. *Contact: DeltaCom 1-800-239-3719*

TAX AUDIT DEFENSE

TaxResources, Inc., the pioneer and largest Tax Audit Defense firm in the U.S. brings to our Association physician members the specialized abilities of over 500 hand picked and specifically trained IRS agents, auditors, and tax attorneys. *Contact: TaxResources, Inc. 1-800-922-8348*

PROFESSIONAL LIABILITY AND OTHER TYPES OF INSURANCE COVERAGE

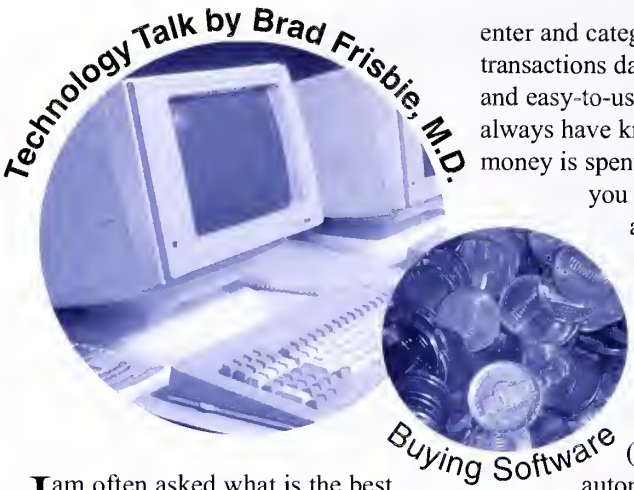
Coverage is available through Mutual Assurance, Inc. of Birmingham, the largest writer of liability insurance for physicians in the state. Mutual Assurance was formed by MASA during the insuranee crisis of the mid 1970's, when liability coverage was suddenly not available to Alabama physicians. Mutual Assurance, Inc. also offers other types of insurance coverage such as disability, life, business overhead. *Contact: Mutual Assurance, Inc. 1-800-282-6242*

HEALTH INSURANCE COVERAGE

MASA endorses Blue Cross Blue Shield group health insurance plans for you and your staff.
Contact: Emmett Wyatt, MASA 1-800-239-6272

PRACTICE MANAGEMENT RESOURCES

United Communications Group offers newsletters and other publieations to help physicians, including: Part B News, Part B Answer Book, Practice Strategies for Managed Care, Physieian Practice Coder, RBRVS FeeCale software, Medicare Compliance Alert and Physician Office Lab News. Exclusive MASA discount available. *Contact: United Communication Group, 1-800-929-4824, Ext. 2238*



I am often asked what is the best software to buy to make that computer purchase more palatable. For anyone who has ever been to CompUSA, Egghead Software, or the like, the array of software is overwhelming, rivaling some grocery stores in their range of choices. In this quarter's issue of MASA Review, I would like to point out those substantial tomes of self-improvement which are cost effective, categorized by home management, productivity, education, internet, and entertainment. Most programs mentioned are available in both PC and MacIntosh versions. As a disclaimer, I have no invested interested in nor am I advertising the products mentioned here. Just good old-fashioned experience.

Home Management

For the past six years, the most important piece of software on my computer has been Quicken, financial tracking software that allows you not only to keep your checkbook balanced, but also to track stocks and obtain investor insights from the internet. As long as you remember to enter and categorize each of your transactions daily using the colorful and easy-to-use interface, you will always have knowledge of how your money is spent. If you are like me, you will often be surprised and enlightened to discover the loose guns in the family. If you are careful to include all your transactions, many tax software programs (I suggest Turbotax) will automatically find Quicken's database and create your tax return. With a few years of practice, you can do away with your CPA!

Quicken has many other features, such as Home Inventory. Quicken allows you to systematically maintain records of valuable items along with value, purchase dates, serial numbers, etc. When all is said and done, Quicken periodically asks you to insert diskettes for data backup which you can password protect and save in a place remote from your computer. There are many other money and home management software packages, but none are quite as refined and elegant as Quicken.

Indispensable is the purchase of a scanner to copy, fax, and archive important documents and family photos. Having used quite a few of these, I recommend spending the extra money for a Hewlett Packard scanner (such as the HP 6P). They are reliable, provide excellent color reproduction, and come with some of the best software on the market for scanning and faxing.

If you wish to have access to

your documents while away from home, consider telephone answering device software for your computer such as Symantec's TalkWorks Pro 2.0. Many can be setup to allow you to request from a remote telephone documents on your computer for faxing to a number of your choosing. My computer stays on 24 hours/day and functions as my telephone answering device. When the power goes out, the software to my Opti-UPS 420E battery backup automatically closes all programs and turns off the computer. When the power comes back up, the computer restarts and all programs reopen where they left off.

Lastly, I can't say enough how much my life improved when I bought my wife a copy of Sierra's Cooking Light. Thousands of recipes are brought up in interactive, multimedia presentations, teaching her how to prepare technically difficult dishes and telling her how much she needs to buy of each ingredient after entering into the program the number of people who will be served. Stunning.

Productivity

Two competing office suites account for the majority of the market share, Microsoft Office and Lotus Smartsuite. Each contain programs that allow you to do word processing, create spreadsheets, databases, and multimedia presentations. I personally use the Lotus products but given the number of documents I receive in Microsoft Word and PowerPoint format, I have to recommend Microsoft Office for general compatibility with the world. There is one Lotus product, however, which you cannot do without and can be bought separate from Smartsuite. Lotus Organizer is a personal information manager which records appointments, addresses and phone numbers, to-do lists, anniversaries, and long-range planning. Many pocket electronic organizers (such as the PalmPilot) come with software that sychronizes with the data in Lotus Organizer.

Another favorite software package of mine is Delorme's Map'n'Go. With incredibly detailed street-level maps of the U.S., you can input two addresses and find the shortest and/or fastest routes between each and print directions. If you own a handheld GPS (Global Positioning Satellite) receiver and a laptop, you have your own in-car navigation system. As I drove to this year's annual assembly in Point Clear, the laptop announced in a computerized voice when and where I was suppose to turn. Very impressive and very much a part of cars in the near future. TravRoute's Door-to-Door is slightly more accurate but much more expensive and requires a proprietary GPS.

Education

Most research can be done by searching the Internet, but a great general encyclopedia on CD is Microsoft's Encarta. No other to date is as well-developed. If you want to know what your patients are reading, pickup Mayo Clinic Family Health. For small children, I suggest Reader Rabbit's Reading 2, Ready for Math with Pooh, and Mathblaster. Older children will be better sources than me

for cutting edge software in education and entertainment (or at least consider themselves so), but I recommend Where in Time is Carmen Sandiego? great history lessons for children and adults.

Internet

As you know, the two premier web-browsers on the market are Netscape Navigator and Microsoft's Internet Explorer 4.0. Both have built in email, news, and conferencing but I recommend Explorer merely because it preconfigures your screen with many links to great websites and includes multimedia software that have to be separately downloaded when using Netscape. It is a three hour download for the full install from http://www.microsoft.com but I would suggest ordering the CD (it is free). The alternative is to buy Windows 98 which incorporates the Explorer into the desktop. I have not had the problems with Windows 98 as mentioned in the press, but I would recommend that if you haven't accumulated a lot of important documents or programs to remove Windows 95 and make a fresh install of Windows 98 for new computers (rather than buying the upgrade for 95 which is a different program). Of course, you will have to re-install all your software but it may be well worth the headache if what the lay press says is true.

I can't help but mention a few websites that routinely benefit me. I buy all my non-perishable groceries through http://www.netgrocer.com. They are delivered Fedex at a substantial savings over going to the grocery store (including the elimination of state sales tax). My plane reservations are made through http://www.travelocity.com. My books are bought through http://amazon.com. Thousands of radio stations simultaneously broadcast on the Internet, many of which are indexed under http://broadcast.com.

While I am preparing this article, I am listening to WTNT, a jazz station in my hometown of Oklahoma City. The bulk of most major newspapers can be accessed through the net, but you can pick and choose what you want to automatically receive through http://www.pointcast.com, including real time stock quotes. Many major stock brokers allow you to trade securely over the net, including http://www.eschwab.com.

Entertainment

I have to be honest. I don't install any games or entertainment software on my computer and so I can't offer much help here. I can recommend some general tips when buying software for Windows 95/98 systems, however. When buying a game, you should generally steer away from any software that is more than two years old, states it can run on Windows 3.1 systems, or requires DOS version x.xx to run. While these programs may run, they will often be uninstal-

lable, overwrite newer files that Windows requires to run, and generally wreak havoc on your system. Programs should be labeled Windows 95 or Windows 95/98 compatible. Any program written for Windows 95 will run on Windows 98.

Conclusion

There are so many great software programs that it would take pages to list them. Avoid impulse buying and get only what you will truly need and use. The more software you place on your computer, the greater the chance of running into conflicts and system crashes. Hopefully this article will give you an orientation to some of the better products.

Conspicuous by its absence is a section on medical software which will be a subject of a future column. Next time, we will discuss the potential impact the Y2K (Year 2000) problem will have on the world's computers and your business. ★

Brad Frisbie, MD
frisbie@wwisp.com

REGIONS PROFESSIONAL SERVICES

As an accomplished professional your time is important. And Regions Bank realizes your demanding schedule requires a different kind of banking. That's why we've developed Regions Professional Services. It's a special service offered only to individuals, like you, who have achieved financial success and deserve special attention. You have unlimited access to your own private banker, an experienced specialist who understands your banking needs and wants to ensure your financial goals are met with uncompromising success.

FOR MORE INFORMATION, PLEASE CONTACT:

Vicky Brown, Montgomery (334) 832-8635 Rusty Allman, Mobile (334) 690-1166
Robert Pless, Birmingham (205) 326-7699 Heike Harris, Tuscaloosa (205) 750-2767
Susan Griffin, Huntsville (256) 535-0261

Regions Bank

www.regionsbank.com/services/privatebanking.html

MEMBER FDIC

upcomin

1999

JANUARY

January 15
The HIV Patient in Your Practice
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

January 19-20
MASA Board of Censors
Montgomery, AL

January 23
Fifteenth Invitational Scientific Symposium
Birmingham, AL
Contact: MASA Education Dept.
(334) 263-6441 or (800) 239-6272

January 26-27
AMASA Winter Board Meeting
Auburn, AL

January 31 - February 2
MASA Governmental Affairs Conference
Washington, D.C.
Contact: MASA Governmental Affairs Dept. (334) 261-2000 or (800) 239-1333

FEBRUARY

February 3-6
Adolescent Medicine Seminar
Lake Buena Vista, FL
Contact: George M. Converse, M.D.
(205) 783-5276
CME Credit: 15 hours Category 1

February 16-17
MASA Board of Censors
Montgomery, AL

February 20-25
Piñata of Pediatrics XI
Costa Rica
Contact: UAB CME Office - Huntsville
(256) 551-4490
CME Credit: 12-15 hours

MARCH

March 2
Legislative Session Begins

March 5-6
MASA Leadership Conference
Birmingham, AL
Contact: MASA Education Dept. (334) 263-6441 (800) 239-6272

March 9
AMASA Legislative Day
Montgomery, AL

March 9-12
15th National Symposium on Child Sexual Abuse
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

March 13
1999 Asthma & Allergy Update
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

March 14-17
Internal Medicine Seminar
Lake Buena Vista, FL
Contact: George M. Converse, M.D.
(205) 783-5276
CME Credit: 15 hours Category 1

March 16-17
MASA Board of Censors
Montgomery, AL

events

March 17-20
Family Practice Seminar
Lake Buena Vista FL
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

March 17-20
Pediatrics Seminar
Lake Buena Vista FL
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

March 21 23
AMA Leadership Conference
Washington, D.C.

APRIL

April 7-11
General Surgery Update
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 19 hours Category 1

April 20-21
MASA Board of Censors
Montgomery, AL

April 21-24
Pediatrics Update
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 15 hours Category 1

April 23-24
17th Annual Review of Modern Therapeutics
Huntsville, AL
Contact: UAB CME Office - Huntsville
(256) 551-4490

April 27 - 29
AMASA Convention
Mobile, AL

MAY

May 18-19
MASA Board of Censors
Montgomery, AL

JUNE

June 8-12
General Surgery Seminar
Hilton Head Island SC
Contact: George M. Converse, MD
(205) 783-5276
CME Credit: 19 hours Category 1

June 6-11
Alabama Academy of Family Physicians
Annual Meeting
Pine Mountain GA
Contact: Holley Midgley (334) 263-6441

June 10-13
1999 MASA Annual Session
Marriott Bay Point, Florida
Contaet:MASA Education Department
(334) 263-6441 or (800) 239-6272

June 14-16
16th Annual Alabama Chapter, Am. College of Emergency Physicians
Annual Meeting & Education Session
Destin FL
Contact: Dr. David Garvey or Leland Holman (334) 265-0068

June 15-19
Adult Infectious Disease Seminar
Hilton Head Island, SC
Contact: George M. Converse, MD
(205) 783-5276

Q: I feel that I am losing control of my patients. Whenever I admit a patient to the hospital I'm constantly on the phone to some reviewer getting permission for treatment or getting a procedure pre-approved. Sometimes I disagree strongly with their directives and I sincerely feel they're painting a target on my back for a malpractice lawsuit. Is there anything I can do, short of pulling out of all the health plans in the state?

A: You've hit the nail on the head; the third parties now involved in healthcare are hard to live with, yet you can hardly live without them. And you're correct in another sense; we are seeing more lawsuits originating from conflicts between physicians' medical judgment and mandates from insurance companies or utilization review organizations.

Sadly, medical/legal experts say the number will continue to rise as physicians find themselves confronted with situations in which third party payers seek to dictate some details of patients' health care. The prime example is the limits some health insurers place on the number of days a patient can stay in a hospital following surgery.

The thing to remember is that it's your patient and your judgment. Risk management experts constantly warn physicians that they should never compromise their clinical judgment to abide by guidelines set by third party payers, and should continue to provide the care that is indicated by the patient's medical condition.

One high-profile lawsuit, Wickline v. Medi-Cal, serves as a strong warning to physicians who encounter such conflicts. The case centered around the defendant managed care organization's denial of a physician's request to extend a patient's hospital stay for complications following vascular surgery. The physician discharged the patient in accordance with the utilization review directive; however, the patient was later readmitted with problems and ultimately lost her leg. The suit resulted in a $500,000 plaintiff verdict against Medi-Cal, which was later overturned by a California appellate court.

Although the treating physician was not named in this suit, the court strongly criticized complacency on the part of the physician regarding third party directives: "The physician

who complies without protest with the limitations imposed by a third party payer, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payer as the liability scapegoat when the consequences of his own determinative medical decisions go sour."

Following are some general suggestions from risk management experts for those times when your clinical judgment differs from guidelines set by a health insurance provider or utilization review board:

1) Discuss the situation in detail with the patient and thoroughly document the discussion in the medical record. For instance, if you feel that a patient should have a longer hospital stay than insurance will permit, make this clear to the patient and explain that the patient would have to bear the expense. This decision should be left with the patient and/or family.

2) If the patient chooses to be discharged anyway, note that in the record. Strongly consider a follow up with a telephone call after such a discharge to be sure the patient is progressing satisfactorily.

3) Carefully document every conversation with an insurance company or health plan; note especially the name of the individual you speak with, as well as the date, time and nature of the conversation.

4) Finally, it is important that complete and thorough documentation be entered in the record in a timely fashion. Without this documentation, it's the physician's word against the patient's. ★

We welcome your risk management or malpractice related questions. You may send them to Amanda Jones at MASA, amanda@masalink.org or 1-800-239-6272; or to Tom Phelps at Mutual Assurance, P. O. Box 590009, Birmingham, AL 35259-0009. Mutual Assurance also provides general risk management assistant for its insureds through its no-cost resource center at (800) 282-6242 or 877-4400 in Birmingham, or on the web at www.medicalassurance.com

Mutual Assurance Opens Risk Resource Center for Insureds

Physicians who are insured with Mutual Assurance, MASA's endorsed professional liability carrier, may phone the company's Risk Resource Center for quiek response to questions about liability issues in their practice. You may reach Karen Everitt or Elizabeth Sheppard in the Risk Resource Center at Mutual Assurance by phoning (800) 282-6242 or (205) 868-9800. Questions may also be submitted via e-mail to rmhelp@maih.com.

A History of Medicine in Alabama

by Howard L. Holley, MD
The University of Alabama
School of Medicine
Birmingham, Alabama, 1982
385 pages

A History of Medicine in Alabama is a book republished and available through the Medical Association. It was written in 1982 by Howard Holley, MD, distinguished professor and teacher of many physicians in our state, including myself. He was originally from Perry County and has many family and friends in our area who remember him fondly.

Why should you want to read a history book written over fifteen years ago? The answer is because it is an excellently written, well-researched chronicle of our profession in our state. The story is timely to the current debate over the future of medicine. Reading this narrative suggests that the more things change, the more they stay the same. Or, to quote Faulkner, "the past is not dead, it is not even past."

Alabama has seen many medical highlights and a few low ones as well. There were always turf wars. Distribution of physicians was always a concern. For instance, in 1850, there were "twenty-seven physicians with diplomas" in Perry County as opposed to forty "regular practitioners" in Mobile County.

Dorothea Dix once came to Selma. The "rehabilitation of inebriates" has always been a much debated topic with little more consensus today than 100 years ago. There is the story of the reformer, Peter Bryce, MD, who came to Alabama to devote his life to humane psychiatric treatment for the people of Alabama, which included confronting armies as well as developing milieu therapy; surely a physician for all seasons. Jerome Cochran, MD, was the father of public health in Alabama and a darned good politician, as well. Dr. Bryce and Dr. Cochran were contemporaries. Their deaths, four years apart, ended an era in Alabama medicine.

The story of the fight against tuberculosis is a valiant public health crusade, particularly in the light of the current struggle against the re-emergence of resistant forms of the disease. It is important to remember that prior to 1950, the disease "killed 90 percent of those reported stricken." At least two Alabama governors were physicians. Alabama has a long tradition of entrusting medical matters to physicians.

I would encourage you to consider this worthy addition to your professional identity. The story of how we got here surely gives guidance to where we go from here. Dr. Holley has produced a lively portrait. I approached it with trepidation and finished it with pride. Many of my teachers from medical school were there. I thought of Dr. Holley, a kindly man with a full professional life and health problems of his own, giving the effort to accumulate and record these volumes of information, much of it obscure. It is a good book.

Reviewed by David W. Hodo, M.D.
Book Editor

UNITED STATES POSTAL SERVICE™

Statement of Ownership, Management, and Circulation

(Required by 39 USC 3685)

1. Publication Title	2. Publication Number	3. Filing Date
MASA Review	0284-7200	9/30/98
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
Quarterly	4	none

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4)

P.O. Box 1900; Montgomery, AL 36102-1900

Contact Person: Amanda Jones
Telephone: 334-263-6441

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer)

P.O. Box 1900; Montgomery, AL 36102-1900

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)

Publisher (Name and complete mailing address)

The Medical Association of the State of Alabama; 19 S Jackson Street; 36102-1900 Montgomery AL

Editor (Name and complete mailing address)

William A Curry, M.D., 271 Nott Hall, Box 870326; Tuscaloosa, AL 35487-0326

Managing Editor (Name and complete mailing address)

Amanda Jones; PO Box 1900; Montgomery AL 36102-1900

10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)

Full Name	Complete Mailing Address
Medical Association of the State of AL	19 S Jackson Street, PO Box 1900 Montgomery, AL 36102-1900

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → X None

Full Name	Complete Mailing Address

12. Tax Status (For completion by nonprofit organizations authorized to mail at special rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☒ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)

PS Form 3526, September 1995 (See Instructions on Reverse)

13. Publication Title	14. Issue Date for Circulation Data Below
MASA Review	Fall April 1998

15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)		6,500	6,500
b. Paid and/or Requested Circulation	(1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales (Not mailed)	0	0
	(2) Paid or Requested Mail Subscriptions (Include advertiser's proof copies and exchange copies)	6,076	6,076
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))		6,076	6,076
d. Free Distribution by Mail (Samples, complimentary, and other free)		0	0
e. Free Distribution Outside the Mail (Carriers or other means)		0	0
f. Total Free Distribution (Sum of 15d and 15e)		0	0
g. Total Distribution (Sum of 15c and 15f)		6,076	6,076
h. Copies not Distributed	(1) Office Use, Leftovers, Spoiled	424	424
	(2) Returns from News Agents	0	0
i. Total (Sum of 15g, 15h(1), and 15h(2))		6,500	6,500
Percent Paid and/or Requested Circulation (15c / 15g x 100)		100 %	100 %

16. Publication of Statement of Ownership
☐ Publication required. Will be printed in the Vol 82 No 3 issue of this publication.
☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner — Date

Amanda Jones — 9/30/98

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
3. Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
4. If the publication had second-class authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or, if the publication is not published during October, the first issue printed after October.
5. In item 16, indicate the date of the issue in which this Statement of Ownership will be published.
6. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form 3526, September 1995 (Reverse)

President *(continued from page 2)*

tions, grievance procedures, and quality assurance. Our primary goal is appropriate access and treatment delivered in the right setting.

Payors and health plans emphasize quality, but how does one define that? To physicians, it is giving the best care to our patients. To payors, it frequently includes "at the lowest possible cost." To health plans, it may mean saving money to put in the hands of their principals and investors. This includes the possibility of intervention in the physician-patient relationship. The executives and medical directors of these organizations are reasonable and talented people. That gives us hope of accomplishing some of our goals.

Although management guidelines exist for a variety of disorders, the art of medicine sometimes requires non-standard diagnostic and treatment regimens. Medicine will never be managed like a Fortune 500 company. Across the nation, health plans are beginning to realize this and this year many of these Wall Street darlings have tumbled from their pedestals, with some getting into serious financial troubles. Additionally, legislative, regulatory, and judicial setbacks in some states have increased the pressure to be more responsive to patient demands. Many plans are calling for significant premium increases for the first time in years. How all this will shake out in Alabama is uncertain at this writing. We intend to keep an open dialogue with all parties, keeping the patients' concerns as our priority.

Federal Legislation

The national move to protect patients' rights got a lot of play in the media this past year. Patients have leveled their anger at managed care nationwide far more than we have witnessed in Alabama, where penetration is currently only about ten percent. News magazines, TV, and even Hollywood got on the bandwagon, highlighting glaring patient tragedies attributed to managed care denials. Not to be outdone, the President presented his Patient Bill of Rights and the House and Senate each had several versions. There was an early House version from Representative Norwood known as PARCA. Unfortunately, many of the items we had hoped for were not in the final Republican House bill that passed. The Republicans decided to please their other constituency ...insurers and business interests.

Our plea with MASA members to write or call our Senators to urge their support for legislation that addressed these issues got an underwhelming response. We wanted a bill which would:

1) ban "gag rules", thereby allowing physicians to discuss all treatment options, whether covered or not by the health plan;

2) give full disclosure of the coverage of the plan to the patient;

3) set up a binding appeals procedure for denials of care which would be reviewed outside the plan by an objective panel;

4) enforce the "prudent lay person" definition for coverage for emergency room visits; and

5) make health plans accountable for their decisions concerning medical necessity.

Well, you know what happened. The Senate got off the hook because of the Clinton-Lewinsky affair diversion, allowing their bills to die, almost unnoticed by the public.

What are the prospects for 1999? With a more evenly divided House of Representatives with new Republican leadership and the Democrats pushing for action, I believe there is a better chance for a bipartisan bill, which should include some of the things we want. A recent poll of voters showed even more support (65 percent) for government intervention and 73percent support for the right to sue health plans. Big business has already come out fighting, stating that legislation will cause significant premium increases and push even more people into the uninsured category.

Why do we need patient protection? Because what is right for the patient is right for us. What other reason do you have for practicing medicine than to benefit your patients. Perhaps our non-legislative efforts will take care of the problem, but while we are negotiating we must continue to follow the dictum: first, do no harm. Managed care has the potential to do just that.

This is why we need you to make voice heard on Capitol Hill, either through your county, state or specialty leaders, or writing or calling your Representative and Senators when you are asked to respond to a legislative or Congressional alert. An excellent opportunity for meeting with Alabama's Congressional delegation will be at MASA's Governmental Affairs Conference on January 31 through February 2 at the Willard Hotel in Washington, D.C. I hope you will all make plans to attend. It does make a difference! We must seize the day! ★

Curry *(continued from page 4)*

honestly with each other about what patients may be doing outside the mainstream of medical care. So it was that Wendy Arthur, M.D. made such a presentation to us last June. An adaptation of her address appears in this issue of MASA Review. While some would argue that mere acknowledgement of such therapies will be mistaken for endorsement, there is another point of view. For one thing, some of this might actually help. For another, the truth is never simple. We have to accept the responsibility for keeping the benefit of openness with our patients in tension with the risk of being misunderstood. The answer either way is clear communication with patients, which is always the right course.

Dr. Arthur is the product of a conventional medical education, and her approach is that of a scientist tempered with compassion for her patients. She does that one thing we all need to do more: she listens to her patients. While few of us are likely to devote the time that she has to learning about CAM, we can benefit from her study and analysis, and we can remember the well-worn motto that all of us have heard since medical school: primum non nocere - first, do no harm.

Elsewhere in this issue, we get a review by David Hodo, M.D. of Dr. Howard Holley's classic A History of Medicine in Alabama, accompanied by William H. Dodson, M.D.'s article on the life and career of Dr. Holley. As one of the architects of the school of medicine in Birmingham, Dr. Holley is remembered warmly by many of our members as a great teacher in the finest Oslerian tradition. In his own words, "The business of the teacher is not to supply information, it is to raise intellectual thirst."

Our thirst for technological literacy is slaked as usual by Brad Frisbee, M.D. in his "Tech Corner," while the parched ground of medical liability exposure is a little less lonely after the advice of Mutual Assurance's column. Finally, Charles Ford, M.D., and Gerry Summer, M.D., give us Part II of their series on the Disruptive Physician, focusing on the role of personality disorders.

This issue marks another turning point in our work on this publication. It will be the last in the smaller format. Starting with the winter issue, we will return to the standard journal size. Think of it as a move from the "alternative" to the "conventional." As always, we'd appreciate hearing from you. ★

References

1. Kleijnen J., Knipschild. P. Gingko biloba for cerebral insufficiency. Br J. Clin Pharm. 1992;34:352-358.

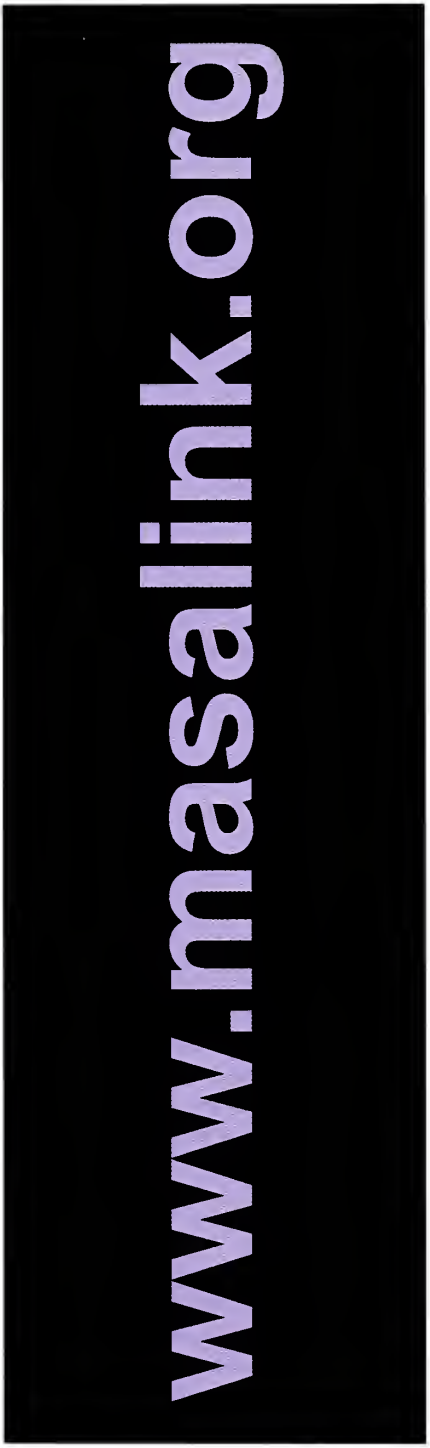
2. Jonas, W.B. The National Institutes of Health Office of Alternative Medicine. Federation Bulletin, 1997; 84(3):152-161.

3. Eisenberg, D.M., Kessler, R.C., Foster, C., Norlock, F.E., Calkins, D.R., Delbanco, T.I. Unconventional medicine in the United States-prevalence, costs, and pat-

terns of use. N Engl J Med. 1993; 328:246-52.

4. Blumberg, D.L., Grant, W.D., Hendricks, S.R., Kamps, C.A., Dewan, M.J. The physician and unconventional medicine. Alternative Therapies in Health & Medicine. 1995;1(3):31-35.

5. Fisher, P., Ward, A. Complementary medicine in Europe. Br Med J. 1994; 309:107-111.



Executive *(continued from page 3)*

and staff do a lot for you, your practice and your patients every day, every day, every day. The difficulty is that much of what we do is intangible. Much of what we do is advocacy and representation. Your multidisciplinary associations are your voices in the legislature and Congress. They meet regularly with regulators, and negotiate with and represent you and your patients before business and third party payers. And since so much is intangible, the only way we can make them tangible is to communicate them to you through newsletters, publications (like this one), the Internet ***(www.masalink.org)*** and meetings. If you're like most physicians you have enough to read and if you go to another meeting, you'll never get to see your kids grow up.

Fourth, your specialty societies are important, no doubt about it. So important, in fact, that MASA and the AMA are making significant attempts to form strategic alliances with specialty societies. We are forming these alliances so that the house of medicine can be more effective by acting together. Think about it. On a state level, a specialty society of 300-400 physicians is a fairly large group. But on a legislative issue, an organization with a seasoned, effective lobbying staff which is backed by over 6,000 members can have a much greater impact.

Oh, by the way. There is one other investment you should make as a physician. That's to get your spouse to join the **Alliance** to the Medical Association of the State of Alabama and its local Alliance chapters. This is a vibrant, energetic group which is making a difference from Ft. Payne to Mobile and Florence to Dothan. They're active legislatively, they're active socioeconomically, and they're active in public health issues. Physician spouses need to be involved in your profession and this is an excellent organization which deserves your and your spouse's support.

Oh, one more thing. Get your office manager involved in the **Medical Group Management Association**. He or she will benefit greatly from the information this group disseminates to raise the level of professionalism among medical practice managers. With the complexities of managed care and government micromanagement, MGMA provides your practice manager with useful information to run your office as efficiently as possible. Networking at its excellent educational offerings will more than pay for your manager's membership.

Well, that's it. Your membership renewal is a long term investment in your professional career. As an investment, you also should be able to measure your ROI (Return On Investment) just like you do with your investment and retirement portfolios. We promise to provide that to you through our various communications media, just like your broker or investment advisor does. That will take some effort on your part to stay informed.

Also, your input is welcomed, be it through surveys, our website, letters to the editor, phone calls, or resolutions to your College of Counsel-

lors and House of Delegates through your county society.

Think about it...if your professional organizations weren't there every day, every day, every day to advocate and represent your professional beliefs and concerns, who would and what would your practice environment be like today and tomorrow?

Invest now in your future. ★

INFORMATION FOR AUTHORS CONCERNING MANUSCRIPTS

Manuscripts from member physicians should be typewritten, double spaced on white paper. Manuscripts may be mailed, faxed or e-mailed to the address below. (E-mail is preferred method.) Authority for approval of all contributions rests with the Editor. *MASA Review* reserves the right to edit any material submitted. The publishers accept no responsibility for opinions expressed by contributors.

Style: The first page should list title, the author(s), degrees and any institutional or other credits. Bibliographies must contain, in the order given: Name of author, title of article, name of periodicals with volume, page, month - day of month if weekly - and year. References should be numbered consecutively in order in which they appear in the text.

Length of Articles: Articles should not exceed 10 printed pages.

Illustrations: Illustrations should be numbered consecutively and indicated in the text. The number, indication of the top and the author's name should be attached to the back of each illustration. Legend should be typed, numbered, and attached to each illustration. Photographs should be clear and distinct; drawings should be made in black ink on white paper. For photographs, glossy prints are preferred.

MASA Review
Attn: Amanda Jones
P.O. Box 1900
Montgomery, AL 36102-1900
1-800-239-6272 phone
(334)-269-5200 fax
amanda@masalink.org

Medical Director
Alabama Physicians Recovery Network

The Medical Association of the State of Alabama is seeking a medical director for its impaired physicians program. PRN has provided for a full time medical director since 1991, is fully developed, nationally recognized and has stable funding. Interested applicants should be familiar with the special issues of physicians involved with substance abuse and have a working knowledge of affective illness and personality disorders. Applicants must have strong interpersonal communication skills. Please send CV and request an application for the position to:

Gerald L. Summer, M.D.
19 South Jackson Street
Montgomery, AL 36104

Defending your reputation is our reputation

Mutual Assurance

Alabama's Finest Malpractice Insurance

POST OFFICE BOX 590009 • BIRMINGHAM, ALABAMA 35259 • 800.282.6242/205.877.4400

**********MIXED AADC 360
COLUMBIA UNIV. 001ADK5294
HEALTH SCIENCES LIBRARY
701 W 168TH ST
NEW YORK NY 10032-2704

COLUMBIA UNIVERSITY LIBRARIES
0049996169